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Mapping Psychological Services for Child Welfare Clients in Australasia

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### Abstract

Given the high prevalence rates of mental health difficulties among child welfare clients, this study attempted to map psychological services for such individuals in New Zealand and Australia. In conducting semi-structured interviews with Principal/Senior-Regional Psychologists and Directors from government departments and non-government organisations working alongside child welfare clients throughout Australasia, this study obtained information pertaining to the nature and scope of psychological services provided by such agencies. The most comprehensive data was obtained for New Zealand and New South Wales, while incomplete data described psychological services in Western Australia and Queensland. The findings of this study highlight the absence of a 'best practice' model among such services in addition to the disparities that exist between the number of care and protection notifications received by the government child welfare departments in New Zealand and New South Wales, and the development of psychological services within these departments. Furthermore, the lack of acknowledgement of the mental health needs of child welfare clients among both government child welfare departments and non-government organisations in these jurisdictions needs to be addressed before such services can be effectively delivered to these vulnerable children and young people.

Key words: Australasia, child welfare, psychological services

### **Mapping Psychological Services for Child Welfare Clients in Australasia**

Child welfare clients comprise some of society's most vulnerable children and young people. These individuals become involved with child welfare services when they are suspected of being, have been, or are being harmed, or when their parents are deemed unable to provide them with sufficient care and protection. Recent government reports estimate that approximately 4,503 and 31,166 children and young people aged 0-17 years are currently placed in out-of-home care across New Zealand and Australia, respectively (Ministry of Social Development, 2009; Australian Institute of Health and Welfare, 2009). In 2008, the number of children and young people classified as clients of Child, Youth and Family, the government child welfare agency of New Zealand, was reported to be around 27,562 (Ministry of Social Development, 2009). These numbers are the result of a significant rise in the number of children and young people brought to the attention of the government child welfare departments in each country. The past five years have seen a dramatic increase in the number of care and protection notifications to such departments in both New Zealand and Australia, from 40,939 and 219,384 respectively, in the year to June 2004, to 89,461 and 317,526 in the same period to June 2008 (Ministry of Social Development, 2009; Australian Institute of Health and Welfare, 2009).

#### **Literature search plan**

In an attempt to introduce the reader to the current empirical research-base pertaining to the mental health needs of child welfare clients, the author conducted a thorough search of relevant databases (PsychInfo and Medline) available through the University of Canterbury. After compiling a list of articles exploring the critical

mental health issues facing child welfare clients, a number of studies were selected for inclusion in this introduction. From this short-list of articles, the researcher selected those deemed to be most relevant to the discussion of mental health issues for child welfare clients. Articles were selected for inclusion when they met all, or the majority, of the following criteria a) published in the last 10 years, b) conducted on a large-scale, c) extensively referenced by other articles, and when possible d) conducted in Australasia. To this end, the articles discussed in this paper reflect the unique nature of the study undertaken here.

### **Mental health difficulties among child welfare clients**

The vulnerability of child welfare clients to mental health difficulties is well documented (Richardson & Joughin, 2000). Recent studies have consistently found prevalence rates of clinically significant mental health difficulties among children in care to be considerably larger than the rate of around 10% demonstrated in the general population (Meltzer, Gatward, Goodman & Ford, 2000). A recent study conducted by Ford, Vostanis, Meltzer and Goodman (2007) investigating the mental health difficulties of 1,253 children aged 5-15 years looked after by local authorities throughout the United Kingdom, found that 46.4% met International Classification of Diseases – tenth revision (ICD-10) diagnostic criteria for at least one psychiatric disorder. In a similar study of 3,803 children aged 2-14 years who were investigated by American county child welfare agencies after reported maltreatment, Burns et al. (2006) found that 47.9% of their sample had clinically significant emotional or behavioural difficulties as measured by the Child Behaviour Checklist (CBCL) and its companion instruments, the Youth Self-Report (YSR) and Teacher Report Form (TRF). Closer to home, an Australian study undertaken in the state of New South

Wales investigated the mental health of 347 children aged 4-11 years residing in court-ordered kinship or foster care. Foster carers rated the emotional and behavioural wellbeing of the children in their care using the CBCL and the Assessment Checklist for Children (ACC), a "...carer-report psychiatric rating scale, measuring behaviours, emotional states, traits and manners of relating to others, as manifested by children in care (Tarren-Sweeney & Hazell, 2006, p. 90)." The authors found that 57% of boys and 53% of girls in their sample had a least one CBCL scale score in the clinical range. With regard to the ACC, 46.6% of boys and 42.7% of girls had total scores in the clinical range (Tarren-Sweeney & Hazell, 2006). Minnis, Everett, Pelosi, Dunn and Knapp (2006) found a prevalence rate of mental health difficulties of 64% among their sample of 228 children aged 5-16 years living in foster care in Central Scotland. The children in this study were identified as experiencing mental health difficulties if their overall score on the Strengths and Difficulties Questionnaire (SDQ) fell within the abnormal or borderline range as rated by their foster carers. Similar prevalence studies have found rates of mental health difficulties among child welfare clients as high as 80% (Lyons, Libman-Mintzer, Kisiel & Shallcross, 1998; Clausen, Landsverk, Ganger, Chadwick & Litrownik, 1998).

The most common disorders found among child welfare clients facing mental health difficulties are behavioural and include Conduct Disorder and Oppositional Defiant Disorder. In the aforementioned Ford et al. (2007) study, an ICD-10 psychiatric diagnosis of 'any behavioural disorder' encompassed the largest proportion of looked after children with at least one diagnosis. Specifically, the behavioural disorders Conduct Disorder and Oppositional Defiant Disorder comprised 26.7% and 12.2% of these children, respectively. Other psychiatric

disorders identified as prevalent among the looked after children involved in this study include 'any anxiety disorder' (11.1%), 'depression' (3.4%), 'hyperkinesis' (8.7%) and 'autistic-spectrum disorder' (2.6%).

The Australian study conducted by Tarren-Sweeney and Hazell (2006) also reported rates of emotional and behavioural difficulty among their sample of children in court-ordered kinship and foster care in New South Wales. The proportion of children whose scores fell in the clinical range on the CBCL was 34.1% (boys) and 26.3% (girls) on the internalising scale, and 55.7% (boys) and 44.4% (girls) on the externalising scale. For both boys and girls in this study, 'attention problems' and 'delinquent behaviour' were the most common difficulties cited among the eight subscales of the CBCL, with around 40% of boys and girls, respectively, experiencing difficulties in these areas.

In the study by Minnis et al. (2006), foster carers were asked to rate the emotional and behavioural wellbeing of the children in their care using the Strengths and Difficulties Questionnaire (SDQ). This behavioural screening instrument comprises five subscales; conduct problems, hyperactivity, emotional problems, peer problems, and prosocial behaviour. The percentage of children in this study reported to exhibit emotional or behavioural difficulties in the abnormal range for each of the four problem subscales were: conduct problems (55%), hyperactivity (45%), emotional problems (34%) and peer problems (54%). While the SDQ, and similarly the CBCL, cannot be utilised as diagnostic tools, foster carer's ratings on each of these subscales nevertheless provide useful information as to the nature of the difficulties encountered by children in care.

Studies have also demonstrated that developmental delays, in addition to mental health difficulties are also common among child welfare clients, particularly



in children younger than five years of age. The most common delay among this younger population of children in out of home care is in the development of language. One study, investigating the health and developmental needs of toddlers and infants in the Philadelphia state child welfare system, found that 57.1% of children exhibited significant delays in this area of development. Other delays of note fell within the cognitive (33.4%) and gross motor (31.2%) domains (Silver et al., 1999). These findings, in collaboration with similar studies that have examined the developmental wellbeing of child welfare clients (Hansen, Mawjee, Barton, Metcalf & Joye, 2004; Veltman & Browne, 2001), point to the high prevalence rates of developmental need among this vulnerable population.

### **Aetiology of mental health difficulties among child welfare clients**

Child welfare clients are vulnerable to mental health difficulties for numerous reasons. Research suggests that the high prevalence rates of psychiatric illness among these individuals can be largely accounted for by a number of environmental, biological and psychological risk factors, which often combine to form the unique experience of child welfare clients. The majority of children and young people placed in out-of-home care are victims of maltreatment, with United States estimates suggesting that 58.4% of these children experience neglect, 21.3% physical abuse and 11.3% sexual abuse (US Department of Health and Human Services, Administration on Children, Youth and Families, 2001). Exposure to such maltreatment can have devastating effects on children's development, the most vulnerable of which include the development of attachment, emotional regulation and a sense of self and others (Mash & Wolfe, 2005). Without the consistent comfort and sensitivity necessary to develop a secure attachment, maltreated infants and

preschoolers experience considerable difficulty developing a reciprocal relationship with their caregiver(s). Rather, the resulting pattern of interaction between infant and caregiver is often embodied by avoidance, inconsistent expressions of physical affection, and general disorientation in what is termed *insecure-disorganised attachment* (Mash & Wolfe, 2005). With regard to the development of emotional regulation, unlike typically developing children, individuals who are the victims of maltreatment experience a world in which expressions of affect often result in disapproval or the instigation of abuse. Thus, maltreated children learn to inhibit their emotional expression and regulation, a process that can often lead to the development of internalising disorders, or alternatively hostile and aggressive reactions towards others (Cicchetti & Rogosch, 2001). Children who have experienced maltreatment also encounter difficulty developing a healthy view of themselves and of their relationships with others. Instead, their representational model of 'self' is often negative and characterised by feelings of guilt, shame or anger; often expressed in the emotional and behavioural disorders so common among maltreated children (Feiring, Taska & Lewis, 2002).

Research has also demonstrated that children who are placed in out-of-home care are more likely to originate from economically disadvantaged communities where resources are few and families are often dependent on income support for daily living. Further risks associated with living in impoverished communities include inadequate access to antenatal care and limited educational opportunities (Pilowsky, 1995). In addition, exposure to community violence has been established as a potentiating factor in the development of subsequent emotional and behavioural problems among child welfare clients (Lynch & Cicchetti, 1998).

It is also widely accepted that many children in out-of-home care have biological parents who are experiencing mental health difficulties themselves, including drug and alcohol misuse. It is often the unpredictable and debilitating nature of a mental illness that interferes with parents' ability to adequately care for their children, and ultimately what brings these families to the attention of child welfare agencies. In an American study investigating the content of calls from concerned members of the general public to a national child protection helpline, 10% of referrals raised concerns about the mental health of the parent or primary caregiver (Lewis & Creighton, 1999). The rates of familial mental illness are often elevated among child welfare clients, with estimates of parental psychopathology in such families ranging from 10-29% (Sheehan, 2005).

While the placement of vulnerable children into out-of-home care is a largely positive move for many children and young people, in some cases this experience can itself exacerbate the mental health difficulties experienced by child welfare clients. A recent report conducted by the Department for Education and Skills in the United Kingdom set about outlining a "... radical package of proposals for change (Department for Education and Skills, 2006, p. 5)" with regard to the wellbeing of children and young people in care. This report, which included consultation with child welfare clients themselves, consistently demonstrated the detrimental impact of placement instability and frequent changes of social worker on the wellbeing of such children and young people. These factors can, however, be viewed as both a cause and effect of the emotional and behavioural difficulties faced by child welfare clients (Newton, Litrownik & Landsverk, 2000).

**Longitudinal outcomes of mental health difficulties among child welfare clients**

Unfortunately, for the majority of child welfare clients, the difficulties experienced throughout childhood and adolescence often continue to affect such individuals well into young adulthood and beyond. Several longitudinal studies have attempted to map the development of this vulnerable population as they move through the welfare system and transition into adulthood without the assistance of the state. One such study, undertaken by Pandiani, Schacht and Banks (2001), examined three-year treatment outcomes of 1,141 adolescents who were served by Vermont state child welfare and juvenile justice agencies at 17 years of age. Follow-up data for these individuals found that 38% of young men were incarcerated in the state of Vermont during the three year follow-up period. Among young women who were historically served by state child protection or juvenile justice agencies, a 33% maternity rate was estimated for the same three-year period. With regard to the mental health of the individuals included in this study, a 3% hospitalisation for behavioural health care rate was found among both men and women over a two year period.

In a Swedish study investigating suicide attempts and severe psychiatric morbidity among 22,305 former child welfare clients, the authors found that, compared to members of the general population, these individuals were four to five times more likely to have attempted suicide in adolescence or young adulthood, and between four and seven times more likely during adolescence, and four to five times more likely during young adulthood to have been hospitalised for a psychiatric illness. Once adjusting for potential confounding variables, risk ratios decreased to two times higher for suicide attempts across both age groups. With regard to psychiatric hospitalisations, risk ratios decreased slightly to between three and four

times higher than the general population during adolescence and between two and three times higher during young adulthood (Vinnerljung, Hjern & Lindblad, 2006).

### **Mental health service use among child welfare clients**

The extensive mental health difficulties experienced by a large proportion of child welfare clients, coupled with the chronic nature of such difficulties, points toward a high level of mental health service need among this vulnerable population. Studies investigating the relationship between the need for and utilisation of mental health services by child welfare clients, however, have found significant discrepancies between these two variables. One such study found that among their sample of 3,803 children aged 2-14 years, of whom 47.9% exhibited clinical need, a mere 15.8% received any speciality mental health service in the 12 month period prior to this investigation. Of the children for whom strong evidence of clinical need was identified, only 11.4% received any form of mental health service. The most common services utilised by these individuals were those held in outpatient settings (22.4%) and in clinics or private practice (19.5%). The authors note that the variables distinguishing children who received mental health services from those who did not were largely similar to the variables identified as influential in differentiating between children with clinically significant need and those without. Such variables include older age, placement in out-of-home care, maltreatment histories other than neglect and biological parents with impaired child-rearing abilities (Burns et al., 2004).

Several other studies investigating the relationship between mental health service need and use by child welfare clients support the conclusions from the study outlined above. Early research in this area, conducted by Garland, Landsverk, Hough

and Ellis-MacLeod (1996), found that among their sample of 702 children aged 2-17 years in foster care, individuals with CBCL scores in the clinical or borderline range were three times more likely to receive mental health services than individuals whose score fell below this cut-off point. In comparing the maltreatment histories of the children in their sample, the authors discovered that children who had been placed in foster care due to exposure to sexual abuse were 4.47 times more likely to receive mental health services than were children with alternative maltreatment histories (physical abuse, neglect, caretaker absence). In addition, the experience of physical abuse prior to placement in foster care was also found to be predictive of mental health service use, compared with maltreatment histories of neglect, which significantly decreased the likelihood of service use. As concluded in the study conducted by Burns et al. (2004), older children and adolescents were more likely to receive mental health services, with 1.37 times greater likelihood of service use for each increase of 2 years in age. Further analyses showed that children with maltreatment histories of sexual abuse had a significantly higher number of outpatient visits than children who had experienced neglect/caretaker absence prior to placement in foster care. Interestingly, a similar pattern was found among children who were in care due to a protective issue, with such individuals demonstrating a significantly higher number of outpatient visits as compared to children with maltreatment histories of neglect/caretaker absence and physical abuse.

In an investigation of 3,592 child welfare clients aged 2-14 years residing in out-of-home care or remaining with their biological parents, the onset of mental health service use was shown to increase immediately following contact with child welfare services across all groups in this study (in-home care with no additional child welfare services, in-home care with additional child welfare services and out-of-

home care). Subsequent to initial contact with child welfare services, the likelihood of the onset of mental health service use decreased to levels equal to or lower than those prior to contact with such services, with the exception of children in out-of-home care. Furthermore, the cumulative percentage of children receiving mental health services in the five month period prior to and 18 months following contact with child welfare services increased most rapidly for individuals in out-of-home care and most slowly for children remaining at home and receiving no further child welfare services. In a comparison of the various levels of child welfare involvement, children in in-home care with no additional child welfare services and children in in-home care with additional child welfare services were .31 and .45 times as likely, respectively, to receive mental health services than children placed in out-of-home care. Additional findings indicated that rates of mental health service use were also related to other variables, such as age, ethnicity and need for mental health service, as measured by scores in the clinical range on the CBCL (Leslie, Hurlburt, James, Landsverk, Slymen & Zhang, 2005).

Longitudinal studies have also investigated the use of mental health services among child welfare clients as they transition from adolescence to young adulthood. The most recent of which, conducted by Ringeisen, Casanueva, Urato and Stambaugh (2009), followed 620 child welfare clients aged 13-15 years over a 6 year period as they transitioned into young adulthood. The authors found that across the 6 year follow-up period the percentage of young people receiving outpatient specialty mental health services decreased significantly; from 47.6% at baseline to 41.0% at 18 month follow-up, 33.5% at 4 year follow-up and 14.3% at 5-6 year follow-up. Of the young people identified as having one or more indicators of mental health need, 23.2% reported utilising outpatient specialty mental health services at the 5-6 year

follow-up. Inpatient mental health services, however, were utilised by fewer young people; 13.3% of young people determined to be in need of mental health services. Among the various outpatient mental health services received by the young people in this study, the greatest declines in use were seen in mental health or community health centres (decline of 80% from baseline to 5-6 year follow-up) and in private services from mental health professionals (decline of 73% from baseline to 5-6 year follow-up). In support of previous studies investigating mental health service use by child welfare clients, young people in this study who were described as 'in need' of such services, of white ethnicity or with Medicaid insurance were more likely to utilise mental health services.

Taken together, these studies not only indicate the high level of mental health service need among child welfare clients, but also importantly the rather large discrepancy between this need and the actual service use reported among this vulnerable population. The studies outlined above are consistent in their findings of relatively low rates of mental health service use among child welfare clients, especially when viewed in light of the well-documented behavioural and emotional difficulties experienced by these children and young people.

The probable reasons for this discrepancy are unclear; however, it is likely that many interacting factors are at work in the relationship between mental health service need and use. One proposal suggests that child welfare clients, particularly those who remain in in-home care, are lacking the significant advocates necessary to access mental health services. While they remain with their biological parents, such children and young people are much less likely to receive these services than their peers placed in out-of home care, who have the benefit of caregivers to actively place pressure on caseworkers for mental health services (Leslie et al., 2005). Additional



research investigating this relationship purports that a lack of adequate mental health screening instruments among child welfare agencies may in part hinder the ability for caseworkers and other professionals to accurately identify those children most in need of mental health services (Levitt, 2009). As a result, a significant proportion of child welfare clients are overlooked and continue their journey through the system with unmet mental health needs. Finally, from the research described above, it can be inferred that a significant number of child welfare clients with mild to moderate behavioural and/or emotional difficulties may not receive the mental health services they require because individuals with more acute presentations draw the attention of caseworkers and are thus referred for such services. Indeed, in the studies outlined above, child welfare clients who scored in the clinical range on measures such as the CBCL (denoting a high level of need) were more likely than children whose scores did not reach such cut-off points to receive mental health services. Among child welfare clients, individuals who are adolescents (as compared to children of younger age), reside in out-of-home care, exhibit clinical need for mental health services via rating scales such as the CBCL, and have maltreatment histories including sexual abuse are more likely than those without such characteristics to receive mental health services.

Despite the discrepancy between mental health service need and use, studies have in fact illustrated that among such vulnerable populations, contact with child welfare agencies serves to increase the likelihood of receiving mental health services. Several studies comparing child welfare clients to children and young people not in contact with child welfare services have shown that, among the former, the rates of mental health service use are increased (Hazen, Hough, Landsverk & Wood, 2004; Becker, Jordan & Larsen, 2006). In addition, as mentioned above, mental health

service use has been demonstrated to increase among child welfare clients upon initial contact with child welfare services, especially when such clients are placed in out-of-home care. This phenomenon suggests that involvement with child welfare services can often serve as a gateway to mental health services (Leslie et al., 2005).

### **Mental health service models**

In light of the research outlining the significant need and subsequent use of mental health services by child welfare clients, a number of studies have attempted to develop and describe such services in order to best serve this vulnerable population. The earliest of these studies, conducted by Arcelus, Bellerby and Vostanis (1999), described a direct access child and adolescent mental health service for children living in residential units or with foster families in Birmingham, England. The service aimed to provide a “cost- effective model of intervention (Arcelus, Bellerby & Vostanis, 1999, p. 236)” in which a comprehensive mental health assessment was promptly conducted in order to assist in the planning of care placements undertaken by the local authority. Referrals were received from residential units, social workers or other agencies working alongside the child or young person and included pertinent information about the reason for referral, current care plan and previous history and/or assessment. The service primarily received referrals regarding difficult behaviour, which reflected the subsequently high rate of conduct disorders diagnosed among children and young people from intake and long stay residential units. With no waiting list, clinics were held weekly at the local child mental health service and intake residential unit, from which the majority of referrals were received. Long-stay residential units and a local foster care agency were gradually introduced to the service, with referrals facilitated by social services. The service involved regular

input from a number of different professionals, including a senior child and adolescent psychiatrist, a community psychiatric nurse, a trainee doctor in child and adolescent psychiatry and a junior trainee doctor in psychiatry. Interestingly, the service received no designated funding and was constructed solely through the utilisation of existing resources. An additional feature of the service was the provision of regular study days on child mental health issues aimed at educating residential care and social work staff. The authors proposed that while this service model was not an entirely innovative approach, it was nevertheless an important one as children and young people in the care of the local authority are often without advocates to request assessment and intervention for the mental health difficulties so prevalent in this vulnerable population. In addition, the authors suggest that “[a] designated service (rather than ‘specialist’, which often mistakenly implies particular skills), or at least a mechanism of coordinating referrals and treatment, in collaboration with the local authority... (p. 242)” would aide in addressing some of the difficulties that arise when attempting to streamline mental health services for child welfare clients in urban centres, such as Birmingham in this case.

Following this model of service provision, Callaghan, Young, Pace and Vostanis (2004) outlined a mental health service for looked after children that served three local authorities in the United Kingdom. The service was initially created to provide mental health services to four groups of vulnerable children and young people; looked after children, young offenders, refugee, and homeless children and families. Referrals were received from a number of professionals and para-professionals working alongside the child or young person, and primarily raised concerns around self-harm, behaviour problems, mood and other emotional difficulties. The mental health team for looked after children consisted of two

primary health workers, two psychologists and a psychiatrist. Together, this team engaged in a number of varied roles according to a three-tiered model of service provision; general and social services (tier one, provided by local Child and Adolescent Mental Health Services [CAMHS]), interface with specialist services (tier two, provided by all members of the looked after children's mental health team) and specialist services (tier three, provided by the psychologists and psychiatrist only). Five-month follow up data revealed that of the 50 cases included in this study, 27 were still open to the team. Among the cases that had since been closed, 10 completed the intervention, 3 were referred to another agency, 3 were closed because the client was non-compliant with treatment and 2 were closed because the client moved out of a residential setting. In addition to this follow-up data, the authors also administered a service satisfaction questionnaire to the foster carers or key workers for each of their clients. An analysis of these questionnaires revealed that looked after children and their carers were involved in a number of different interventions, of which 51.3% believed the suggested treatment was effective and 71.8% reported improvement in the child or young person during treatment. The authors note that while the majority of CAMHS services provided to vulnerable populations, such as looked after children, are often short-term initiatives birthed from limited funding pools; an evaluation of the service outlined above indicates that "...an appropriately resourced service can address the needs of a highly vulnerable client population (pp. 141)". Thus, in providing such a service, the looked after children's mental health team worked to reduce delays in the execution of client's care plans, moderate the need for superfluous mental health assessments and freed CAMHS services of a number of complex and time-consuming cases.

An American study describing a new mental health approach to the treatment of children and young people in out-of-home care at two foster care agencies in New York City reported similar success. This initiative was developed out of an increasing awareness for the specific mental health needs of children and young people in foster care, including addressing trauma. The aims of this project were i) to illustrate that mental health services could play an integral part in improving child welfare outcomes, ii) to make mental health services more accessible by placing clinicians on site at foster care agencies, and iii) to establish empirical evidence of a successful approach to mental health service provision that could be sustained by state funding and replicated elsewhere. Referrals to both services were characterised by profiles at high risk for replacement, including multiple past placements, non-responsiveness to foster parent authority, academic difficulties in school, aggressive behaviours, sexualised behaviours and familial history of mental illness and/or substance abuse. In addition to the staff already employed by the existing foster care agencies, a qualified therapeutic social worker with relevant experience in mental health care and foster care was placed at each service. Three year follow up data revealed a combined placement transfer rate of 4.6% at both services compared to the citywide transfer rate of 25.3% in 2004 and 30.3% in 2005. Since its inception in 2004, the New York State Office of Mental Health has licensed a total of six mental health clinics based on this model at six foster care agencies throughout the city. In a final statement the authors note that “... the model holds promise for more efficient use of mental health care... when services are provided on site, children (and foster and biological families) are much more likely to complete treatment. The alternative is an ultimately ‘wasteful’ starting and stopping of services based on perceiving

mental health problems as disconnected crisis-based episodes (Collado & Levine, 2007, p. 149)".

Finally, in a survey of mental health service provision to residential treatment centres in the state of New York, Baker, Fulmore and Collins (2008) evaluated the provision of such services, satisfaction with current services and suggestions for improvement in five areas: therapeutic milieu, individual therapy, group therapy, family therapy and psychiatric services. With a response rate of 86%, surveys were completed by the staff members at each residential treatment centre (RTC) who were most familiar with mental health services. Results indicated that the majority of RTCs were currently utilising a behaviour management/level system model of therapeutic milieu. Other models of significance included a peer/social skills model and team approach/strengths model. The most common suggestions for improvement in this area were more qualified staff (38.2%) and more training (38.2%). With regard to individual therapy, sessions were most likely to be conducted by therapeutic social workers and occurred weekly at 78.4% of RTCs. The models utilised in these sessions were most likely to be cognitive-behavioural or psychoanalytic in nature. Suggestions for improvement in this area included smaller caseloads/more staff (44.1%) and more money for training (23.5%). In the majority of RTCs included in this study, more than 75% of young people at any one site participated in group therapy sessions which focused on a variety of topics, ranging from anger management to substance abuse prevention, problematic sexualised behaviour and grief and loss. Common suggestions for improvement included more staffing/more staff time (44.1%) and more groups (29.4%). Family therapy was also offered at the majority of RTCs; however, most sites reported a participation rate of just 26-50%. A wide range of models were utilised by therapists in family therapy

including systems, structural, cognitive or an eclectic mix of several models. More family compliance (45.7%) and lower caseloads/more staff (28.6%) were rated the most common suggestions for improvement. Finally, with regard to psychiatric services, 70.3% of all RTCs included in this study employed at least one board-certified child psychiatrist. The percentage of children and young people currently prescribed psychotropic medication varied greatly between RTCs with the majority of sites reporting at least half of all residents on some form of such medication. The most common suggestion for improvement (an impressive 73.5%) was more money for staff. This study illustrates the relative dissatisfaction with mental health services among RTCs in New York State. Of particular note was the severity of the presenting problems among the children and young people serviced by these RTCs, as evidenced by the large percentage of individuals who were currently prescribe psychotropic medication. The authors suggest that "... the severity of youth's problems impedes delivery of mental health services because there are insufficient funds for agencies to provide the services necessary to treat these highly troubled youth (pp. 351)". The issue of securing adequate funding for the provision of mental health services to child welfare clients appears to be a universal barrier against delivering such services to this vulnerable population.

### **Rationale for the present study**

Given the significant number of child welfare clients who experience mental health difficulties in childhood and adolescence, coupled with the fact that many of these individuals continue to experience such difficulties well into adulthood, it is important to investigate the nature of the mental health services provided to this vulnerable population. In order to effectively meet the needs of the thousands of

children and young people in the child welfare system, especially those for whom mental health difficulties significantly interfere with daily functioning, such an investigation must seek to identify the processes through which child welfare clients initially receive mental health services, the nature of these services (including which professionals are providing them) and to which agencies clients are referred for further specialist services. In this way, mental health services for child welfare clients can be successfully mapped and limitations within the system uncovered and subsequently addressed.

To the author's knowledge a study of this nature has not been undertaken either locally or internationally. Research along similar lines has, however, been conducted in England and the United States in which individual mental health services for child welfare clients have been described and evaluated. While the studies outlined above provide useful information regarding the provision of mental health services for child welfare clients within the jurisdictions in which they were conducted, to date an investigation of such services across entire countries, or across *all* child welfare agencies in one state, has not been conducted. The present study set about undertaking such a task in Australasia by posing the following question: What is the current scope of psychological service provision for child welfare clients in Australia and New Zealand? Specifically, this study aims to a) provide an overview of the scope of child welfare psychological services within the Australian states and New Zealand b) compare and contrast the provision of such services within the Australian states and New Zealand, and c) examine the role of psychologists in non-welfare agencies, such as health and education. This study utilises the term *psychological services* in place of mental health services in order to emphasise the



breadth of assessment and intervention provided to child welfare clients in child welfare departments and non-government organisations alike throughout Australasia.

## **Method**

### **Study design**

As an extensive mapping exercise, this study set about mapping psychological services for child welfare clients across Australasia. This study did not employ a sampling procedure; instead it attempted to recruit 100% of potential respondents from eligible agencies working alongside child welfare clients in New Zealand or any of the eight Australian states and territories. This was achieved by contacting the national and state government child welfare departments in each jurisdiction in the first instance, followed by the largest non-government organisations known to deliver services to child welfare clients. Prior to commencing data collection, a submission was made to the University of Canterbury Human Ethics Committee who subsequently granted the researcher ethical approval to undertake the study.

### **Respondent recruitment procedure**

This study recruited respondents from child welfare agencies with and without the capacity to deliver psychological services to child welfare clients across New Zealand and Australia. Such agencies ranged from national or state government child welfare and health departments to community-based, non-government organisations. Agencies working alongside child welfare clients were initially located via national and state government websites and child welfare agency

collectives, such as the Association of Children's Welfare Agencies (ACWA). In addition to these sources, potential respondents were also obtained from the researcher's supervisor, who contributed a number of contacts that were acquired through the distribution of the Assessment Checklist for Children (ACC). In cases where respondents reported referring clients externally for psychological services to alternate agencies, these agencies were also contacted and presented with an opportunity to participate in this study.

For agencies that provided in-house psychological services to clients, the name and contact details of the Principal/Senior-Regional Psychologist of such services were acquired and an e-mail comprising of an official Information Sheet and a request for potential respondents' participation in the study was sent to these individuals. This Information Sheet also included a unique six figure code that was utilised to identify respondents at the initiation of a telephone interview. In cases where potential respondents required authorisation to participate in the study, such individuals were encouraged to pass on any relevant information to agency management in order for the necessary approval to be granted. Once such authorisation was complete, the recruitment process proceeded as planned. Upon registering their interest to participate in the study, Principal/Senior-Regional Psychologists were asked to identify a suitable time when a brief telephone call could be made by the researcher to administer several interview questions. For agencies that reported referring clients externally for psychological services, the name and contact details of the Director of the agency, or other relevant personnel best suited to answer questions about the provision of mental health services to clients, were obtained. An identical e-mail outlining the study and requesting potential

respondents' participation in the study was sent to these individuals as in the case of recruiting Principal/Senior-Regional Psychologists.

As previously mentioned, the government child welfare department within each jurisdiction was initially contacted, in addition to leading non-government organisations delivering child welfare services to vulnerable children and young people throughout New Zealand and the Australian states and territories. During the interview process, the names of additional agencies to which child welfare clients were reportedly referred for psychological services were acquired. Following the collection of this information, an on-line version of the White Pages™ was utilised to gain contact details for the Principal/Senior-Regional Psychologist of these agencies in order to recommence the recruitment process.

### **Data collection procedure**

The primary method of data collection was through the administration of a semi-structured telephone interview to all respondents. During the scheduled telephone call with each Principal/Senior-Regional Psychologist, and before commencing the formal interview questions, respondents were required to recite the six figure identification code contained within the Information Sheet that was attached to an initial e-mail sent by the researcher. Following this, informed consent to participate in this study was obtained from respondents, who were read a series of statements and asked to respond with a verbal affirmation after each to indicate their agreement. Once the structured interview questions were administered, the researcher facilitated further open-ended discussion with each Principal/Senior-Regional Psychologist which included a diverse range of topics depending on the individual respondent.

Directors of agencies without an in-house psychological service were also required to recite the individualised code contained within their Information Sheet and followed the identical procedure for declaring informed consent as was utilised with the Principal/Senior-Regional Psychologists in the previous category. Furthermore, Directors were administered the same interview questions, with the exception of describing an in-house psychological service, for obvious reasons. These respondents were also encouraged to engage in open-ended discussion facilitated by the researcher.

Throughout the interview, and subsequent open-ended discussion, the researcher took detailed notes on the content of conversation which took place with both Principal/Senior-Regional Psychologists and Directors of agencies working alongside child welfare clients. These notes were coded with the respondents' corresponding six figure code and stored in a locked filing cabinet. Following the completion of the interview, a copy of the researcher's notes was e-mailed to respective respondents for their perusal and to allow the opportunity for any amendments to be made to these notes before they were compiled with all other transcripts.

The average duration of these interviews was approximately 25 minutes, with individual interviews varying depending on the length of open-ended discussion with the researcher. Respondents who were the Directors of non-government agencies working alongside child welfare clients in New Zealand and Australia typically engaged in interviews of shorter duration than the anticipated 20 minute period, as the description of their respective agency did not include in-house psychological services.

**Interview**

The semi-structured interview consisted of four core topics of interest and asked respondents about the criteria for selecting clients for psychological services, referral practices and the nature of the services provided to clients within their respective agency. In addition, the interview also allowed opportunity for open-ended discussion between the researcher and respondents on additional topics. Each of the questions included in this interview were developed in order to elicit specific information as to the nature and scope of services provided to child welfare clients in each jurisdiction throughout Australasia.

In an attempt to determine which clients were receiving psychological services and which were not, the following question was developed. This question allowed for the identification of specific patterns among the characteristics of clients being referred for such services; for example, the nature of presenting problems, age, gender and other agency involvement.

What criteria or policies, if any, does your agency utilise to select clients for psychological services? Inclusionary and exclusionary.

Information was also sought regarding the provision of psychological services to these clients. Specifically, whether the agency delivered such services through a team of in-house psychologists, or alternatively, whether clients were referred externally for such services. Thus, the number of agencies providing in-house psychological services could be determined, and for those without these services, the names of other agencies to which clients were referred could be followed up and presented with an opportunity to participate in this study. The following question was designed to elicit such information.

Who provides psychological services to clients within your agency?

In-house?

Fee-for-service?

Referral to other agencies (health, education etc)?

For agencies that were determined to offer in-house psychological services to clients, specific information about the nature of such services was required in order to determine the process involved in developing the in-house psychological service, the aims of the service and details around the number, location and professional responsibilities of psychologists employed by each agency. This information allowed for the comparison of in-house psychological services among various agencies and for the identification of agencies that provided such services to a large proportion of child welfare clients. The following series of questions were asked of respondents in order to obtain a detailed description of the in-house psychological services provided by their respective agency.

If relevant, briefly describe the history of your in-house service. Describe the size, coverage and purpose of your in-house psychological service.

How many psychologists are employed by your agency?

Where are these psychologists located?

What types of work do these psychologists perform?

What types of clients do these psychologists work with?

For agencies that reported referring clients externally for psychological services, information was elicited from respondents about whether their respective agency had given any consideration to developing an in-house psychological service. This information provided insight into an agency's satisfaction with current processes around referring clients for such services and whether respondents perceived a need for in-house psychological services.

If the agency does not provide in-house psychological services. Has your agency considered introducing an in-house psychological service?

## **Results**

### **Distribution of respondents across jurisdictions**

Table 1 displays the distribution of respondents across New Zealand and three of the eight Australian states (New South Wales, Western Australia and Queensland). The majority of respondents (53.8%) represented agencies that were located in the Australian state of New South Wales. Respondents from New Zealand (30.8%) comprised the next largest proportion of total respondents in this study, while those in the remaining Australian states, Western Australia and Queensland, had equal distributions of respondents with 7.7%, respectively. While potential respondents were contacted in several of the remaining Australian states, the response rate was sufficiently limited such that neither Principal/Senior-Regional Psychologists nor Directors of eligible agencies were interviewed over the course of this study.

With respect to the nature of the respondents included in this study, Table 1 illustrates the proportion of Principal/Senior-Regional Psychologists verses Directors of agencies across New Zealand and three Australian states (New South Wales, Western Australia and Queensland). In total, a slightly higher proportion of Principal/Senior-Regional Psychologists (57.7%) than Directors of agencies (42.3%) were included in this study, indicating a correspondingly higher proportion of agencies utilising in-house psychological services, as opposed to referring clients elsewhere for such services. Within New Zealand, almost three quarters of the

respondents were the Principal/Senior-Regional Psychologists of agencies providing psychological services to child welfare clients. In some instances, several psychologists from different geographical areas serviced by the same agency were contacted in order to respond to questions about the nature of the psychological services provided in their respective jurisdictions. These professionals are referred to as Senior-Regional Psychologists throughout this paper for clarification. Specifically, respondents from New Zealand comprised of three psychologists from various geographical areas within the national government child welfare department, two Principal/Senior-Regional Psychologists from two different non-government child welfare agencies and two Directors of agencies working alongside child welfare clients.

Table 1. *Distribution of respondents across jurisdictions*

	Nation/State									
Respondents	NZ		NSW		WA		QLD		Total	
	N	%	N	%	N	%	N	%	N	%
Principal/Senior-Regional Psychologists	5	23.1	8	26.9	2	7.7	0	0	15	57.7
Directors of agencies	2	7.7	6	26.9	0	0	2	7.7	10	42.3
Total	7	30.8	14	53.8	2	7.7	2	7.7	25	100

NZ: New Zealand, NSW: New South Wales, WA: Western Australia, QLD: Queensland.

The distribution of respondents in the Australian state of New South Wales was more balanced among Principal/Senior-Regional Psychologists and Directors of agencies eligible for this study. Respondents from this state comprised of one Principal/Senior-Regional Psychologist from the state child welfare department, two Principal/Senior-Regional Psychologists from the state health department, five Principal/Senior-Regional Psychologists from various non-government organisations



and six Directors of agencies working alongside child welfare clients in New South Wales.

With respect to the nature of respondents from Western Australia, both respondents were psychologists working within the state child welfare department. No Directors of agencies servicing child welfare clients were including in this state. In the state of Queensland, however, the opposite was true with respondents comprising of Directors of eligible agencies only. The Principal/Senior-Regional Psychologists who were contacted as potential respondents from Queensland in this study did not register their interest within the allocated timeframe.

Given that the most comprehensive data were gathered in New Zealand and the Australian state of New South Wales, the initial aims of this project, which included attempting to map psychological services for child welfare clients throughout Australasia, were only realised in those locations, however, this presents an opportunity for the comparison of such services between these two jurisdictions.

As is evident from the data displayed in Table 1, the scope of information in a geographical sense, and to some extent in the nature of respondents from particular Australian states, is not as comprehensive as initially anticipated at the outset of this project. The information obtained from Western Australia and Queensland is lacking in respondents who are Directors of agencies and Principal/Senior-Regional Psychologists, respectively. Furthermore, with only two respondents in each of these states, a complete picture of the provision of psychological services to child welfare clients within such jurisdictions cannot be effectively mapped. This is in part due to the time constraints of the project, which meant that an extensive search of the relevant agencies within Western Australia and Queensland was not possible. While the state of Queensland was initially targeted as an area in which a wealth of

information was expected to be obtained, the poor response rate from potential respondents unfortunately resulted in a much less than comprehensive description of the provision of psychological services to child welfare clients in this state.

As previously mentioned, potential respondents were also contacted in several of the remaining Australian states not included in this study (Australian Capital Territory, Tasmania, Northern Territory, Victoria and South Australia). Similarly to the state of Queensland, potential respondents in these remaining five states did not register their interest in participating in this study within the allocated timeframe. Without information pertaining to the provision of psychological services to child welfare clients, these states were consequently excluded from this study.

## **New Zealand**

### *National child welfare department*

The primary avenue for child welfare clients to receive psychological services in New Zealand is through the government child welfare department which operates service centres in numerous cities and townships throughout New Zealand. While there are slightly different processes involved in referring clients for psychological services within this department, depending on the geographical area in which the service is located, in all centres a referral for psychological services is initially made by a client's social worker. According to the respondents from this department, a social worker will often engage in consultation with a number of other professionals who are involved in a client's wellbeing, such as caregivers, school teachers and paediatricians, before filing an official referral. The referral process is then spearheaded by the social worker who in most cases makes a direct referral for psychological services. Within the Christchurch branch of this department, however,

social workers submit a referral for such services to a Care Team Supervisor, who then approves the request for these services and forwards it to the Principal/Senior-Regional Psychologist within this branch of the department. In other centres, such as Central Auckland, a triage system is in operation where the most acute cases are given priority for psychological services.

According to respondents from the child welfare department of New Zealand, this department operates four Specialist Service Units (SSUs) in Auckland, Tauranga, Waikato and Christchurch. With approximately 20 psychologists employed by this department in various capacities throughout the country, over 90% of such professionals are located in the North Island of New Zealand; a geographical area that contains around 75% of the nation's total children in care. The SSU based in Auckland is described as the most functional of such units in the country. It is also the largest service, spanning the geographical area from Kaitia, New Zealand's northern-most town, to South Auckland. The central office in the heart of Auckland follows a multi-agency model in which child abuse units operated by the New Zealand Police and local District Health Board work collaboratively with staff from this government child welfare department; all of which have been located at the same site since 2002. In addition to these child abuse units, the Auckland SSU also works closely with the Child and Adolescent Liaison Service (CALs), a joint venture between this government child welfare department and the local District Health Board, which also provides psychological services to child welfare clients. Referrals are also made to other agencies, including services provided by local District Health Boards, the Accident Compensation Corporation (ACC), non-government organisations working alongside children and young people with specific needs, such as intellectual disability, and counselling services such as Barnardos. In addition,

non-government organisations holding service contracts with the national child welfare department, and comprising of in-house psychological services, are also utilised to provide such services to child welfare clients.

Across its entire jurisdiction, the Auckland SSU reportedly employs 27 staff, including 13 psychologists and 6 psychotherapists. Specifically, these psychologists are located at three sites throughout greater Auckland and Northland; 7 psychologists in Central Auckland, 5 psychologists in South Auckland and one, currently vacant position in Northland. Psychologists employed within the Auckland SSU engage in a number of professional endeavours including psychological assessments of children and their parents, needs assessments related to trauma, and what are described as 'higher-end' parenting assessments from which decisions are made as to whether a child should be returned to their parent's care. Additional assessments include specialist observations of attachment utilising the Strange Situation paradigm and forensic assessments of children and young people with reported maltreatment histories of physical and/or sexual abuse. Psychologists within the Auckland SSU are also involved in providing psychological interventions to children, young people and their families. Such interventions include Parent-Child Interaction Therapy to address attachment issues and trauma focussed Cognitive Behavioural Therapy, which is utilised with clients up to 16 years of age. The role of a psychologist also consists of providing consultation to social workers, attending Family Group Conferences and multidisciplinary meetings, and delivering psychological services at a weekly site clinic. Further to the assessment and intervention outlined above, psychologists also work closely within an onsite evidential unit where children and young people are interviewed under Evidence Amendment Act (2007) regulations. Within this unit, psychologists typically work with a child or young person for three

to four sessions, during which time completing a developmental screen, family safety assessment, KeepSafe intervention and engaging in discussion with the child or young person themselves.

In contrast to New Zealand's largest psychological service within this government child welfare department, the Christchurch SSU, the only unit in the entire South Island, is the nation's smallest. This SSU consists of a single 0.8 equivalent psychologist. Given the limited resources of this service, the structure and function of the Christchurch SSU is somewhat different to that described in the Auckland unit. Specifically, the sole psychologist performs psychological assessment, therapeutic intervention and fulfils a consultative role by providing psychoeducation to other staff members within the service. Approximately three-quarters of the work undertaken by this psychologist takes the form of consultation with social workers and other professionals within the service. As the sole psychologist for the Province of Canterbury, it is estimated that around 180 social workers from six sites contact the Christchurch SSU each year with requests for assistance regarding approximately 320 children and young people aged 0-16 years. In addition to the in-house service provided by the Christchurch SSU, referrals are also frequently made to other agencies including various services of the Canterbury District Health Board, Ministry of Education and Department of Corrections, in addition to local non-government organisations approved by the national child welfare department.

The development of psychological services within the Christchurch branch of this department began in 1978 with a single, full-time Child Therapist in addition to a consultant psychiatrist who visited the service 2-3 times a week. After two years, this sole Child Therapist was relocated to a Residential Home also run by the national

child welfare department. With the reformed title of Senior Counsellor, this position was in existence for 10 years, until it was disestablished in 1990. In the early 1990s, Christchurch Specialist Services was established with a staff of approximately 10 psychologists; however, government reforms in the mid-1990s saw these positions gradually decline to the single psychologist who remains today.

Information obtained during the course of this study alluded to the suggestion that a national review of Specialist Services within the government child welfare department is scheduled for 2010. This review, which commenced in late 2009, has recently been suspended due to other project priorities and is rescheduled for completion later this year. Furthermore, a recent review of Residential Services conducted by the New Zealand child welfare department has seen the significant restructuring of such services, including the addition of 1.5 full-time equivalent psychologists to one of the nation's four Care and Protection Residences in Christchurch.

#### *Non-government organisations with in-house psychological services*

In addition to the national child welfare department, several non-government organisations also provide psychological services to child welfare clients in New Zealand. Many of these organisations are contracted by this government department to provide such services to vulnerable children and young people throughout the country, as in the case of the organisations included in this study. One such organisation reports employing fairly flexible criteria in accepting clients to the residential home and accompanying psychological services it provides to child welfare clients. Referrals can be received from a number of individuals, including child welfare professionals and concerned members of the general public. The

majority of referrals received by this organisation are for short-term residential services in which children aged 3-12 years spend anywhere from a few days to several months at the residence in order to provide a period of respite for parents or caregivers of these clients. To some extent, all children who stay at the residential home are involved in psychological intervention in the form of a behaviourally-based management system; however, not all residents receive more extensive psychological assessment or intervention. Clients within this organisation are referred internally for such assessment and/or intervention on a needs basis, and while the delivery of psychological services primarily occurs through an in-house service, clients are occasionally referred to other agencies, such as community mental health services run by the local District Health Board. A collaborative approach is taken to the management of client's mental health needs by the psychological team within this organisation and the other services to which a client may be referred.

The psychological service located within this residential home initially began around 4 ½ years ago when staff at the agency became frustrated with the difficulty they encountered in attempting to source psychological services for their clients. In response to this frustration, a psychological service was established from the ground up by a full-time psychologist who was employed by the agency for such purposes. Recent developments have also seen the inclusion of an additional psychologist who provides an outreach service from the agency. These psychologists are involved in numerous tasks, including reviewing relevant documents, case notes and incident reports, engaging in frequent communication with other services, developing and ensuring the quality of care plans, conducting psychological assessment and intervention with children and families, and providing training to other members of the residential team.

Among the non-government organisations providing in-house psychological services to child welfare clients in New Zealand, an alternate organisation to that described above indicated much more stringent criteria in accepting clients into the service. This organisation works closely with the New Zealand child welfare department, and as such only accepts referrals from this department. In addition, children and young people who are referred to this organisation for psychological services must have sufficient evidence of long standing, severe behaviour difficulties. This organisation reports operating an exclusive in-house psychological service, which includes limited referrals to other agencies. The exception is of course a close partnership with the national child welfare department from which referrals are initially received.

This organisation has been in operation for approximately 15 years, and was initially developed as a Conduct Disorder programme by two prominent child and adolescent psychiatrists who were invited by the national child welfare agency of the time to design a treatment programme for young people diagnosed with severe presentations of this behavioural disorder. It currently serves children and young people aged 10-16 years who are clients of the national child welfare department and who are determined to be likely to benefit from behaviour modification. Within this agency, between 5-6 psychologists and one consultant psychiatrist are employed at any one time. Psychologists are involved in assessment and intervention, implementing and monitoring behaviour modification programmes, and general clinical oversight. Psychologists are also involved in the numerous additional programmes run by this organisation, including in-home programmes which utilise Multi-Systemic Therapy and Functional Family Therapy, three residential homes catering for five young males each who reside at the home for an average period of 3-



6 months, Multidimensional Therapeutic Foster Care (a community-based treatment alternative for young people aged 12-17 years who have a history of offending) , and a nationwide individualised behaviour management programme.

*Non-government organisations without in-house psychological services*

In addition to the national child welfare department and non-government organisations with in-house psychological services such as those described above there also exists a small number of non-government organisations that work alongside child welfare clients in New Zealand, but do not consist of in-house psychological services. Such organisations included in this study are both prominent non-government organisations that provide foster care services, among numerous others, to child welfare clients. Neither organisation was determined to employ psychologists as part of the professional team dedicated to working with children, young people and families in foster care, however both report offering counselling services to the clients in their care.

One such agency, which operates as a New Zealand branch of an international organisation established in the late 1900s, reports receiving referrals for foster care and counselling services through a number of different avenues. A significant proportion of referrals to this agency originate from social workers employed by the national child welfare department, however, referrals are also received from community agencies and concerned members of the general public. In addition to offering foster care and counselling services, this agency is also contracted by the national child welfare department to run a 12 bed residence for youth sexual offenders who are under the guardianship of this government department. Given the absence of psychological services provided by this agency, children and young

people who are deemed in need of such services are either referred internally to the child-centred counselling team, or in more severe presentations, to community mental health services run by local District Health Boards.

As in the case of the organisation described above, another non-government organisation without in-house psychological services is likewise a national provider of foster care services to child welfare clients. This Christian social service agency was established in the late 1970s as an alternative to child welfare department family homes and became a nationwide organisation in the mid 1980s. It currently operates 13 service centres across New Zealand, each of which providing foster care services to local child welfare clients. In addition, three service centres offer counselling services to such clients. Similarly to the agency previously described, referrals to these service centres are received by social workers employed by the national child welfare department, professionals from community organisations, such as teachers or General Practitioners, and concerned members of the general public. Clients who present with significant mental health needs are internally referred for counselling within the centres that offer such services and to local government health services, such as Child and Adolescent Mental Health Services.

## **New South Wales**

### *State child welfare department*

The state child welfare department is the largest provider of psychological services to child welfare clients in New South Wales; however, this department also holds a number of service contracts in various forms with non-government organisations throughout the state. These organisations describe a close relationship with the state child welfare department; engaging in frequent communication with

case workers and providing additional information to reports of child maltreatment. Furthermore, a proportion of the referrals received by the in-house psychological service of the state child welfare department originate from non-government organisations without such services and that hold service contracts with this department. Within the state child welfare department, a case worker or manager may refer a client for psychological services to the in-house specialist team of psychologists. Once received, it is the responsibility of such psychologists to gain informed consent from the client (and appropriate parents or caregivers) before beginning assessment or intervention. In addition to the in-house service operated by this department, referral to private practitioners and other government services such as Child and Adolescent Mental Health Services or Drug and Alcohol Services within the state health department occurs when the case load of psychologists is too large, or when gaining access to an in-house psychologist is not possible.

The in-house psychological service within this child welfare department began in the mid 1960s when its offices throughout the state saw the need for a service that could address the behavioural and emotional difficulties of the clients within this agency. The service initially began in Sydney with three psychologists who operated what is described as a 'fly-in, fly-out' service, visiting offices across New South Wales. Over the past 50 years this service has gradually developed into its current existence, where around 65 psychologists are employed across the state. These psychologists are employed within psychological services in metropolitan Sydney and 7 regions across New South Wales. Each region consists of a team leader and approximately 6 or 7 psychologists who are based at individual sites throughout the region. At each site, psychologists work with children and young people displaying anxiety disorders, mood disorders and behavioural issues, including

Oppositional Defiant Disorder and Conduct Disorder. Several psychologists are also seconded to psychological services delivered by the state health department for a fixed term of approximately two years; the first of which is spent working closely with other clinicians and psychiatrists. These psychologists also have fewer clients on their case load and hold less responsibility than the clinical health psychologists working within these health services. In addition, trainee psychologists interning at the state child welfare department often spend a period of time working within such services provided by the state health department.

Psychologists engage in numerous assessments in their work with such individuals, including assessments of parenting capacity, bonding and attachment, extended family and of a child or young person's psychosocial and educational needs. Such assessments may be completed either for a client's case worker, or to inform guardianship decisions made by the court. In addition, therapeutic work conducted by psychologists may be undertaken with foster carers or the children and young people themselves. Therapeutic work with natural parents is generally referred out to other government agencies, such as those previously described. Psychologists within this department are also involved in providing management advice and psychoeducation to foster carers and kinship carers. Such advice is also offered to staff members of the state child welfare department in the form of regular training sessions.

#### *State health department*

Two services within the state health department are included in this study. These services provide specialist psychological assessment and intervention to child welfare clients who are primarily referred by the state child welfare department.

Specifically, one such service reports receiving referrals exclusively from this department and from Joint Investigative Response Teams located throughout New South Wales. Clients who are referred from these services range in age from 0-18 years and have substantiated experiences of abuse as determined by investigations conducted by the state child welfare department. Such clients may be residing in foster care or kinship care placements, or alternatively with their biological parents. It is a requirement of this service that case workers demonstrate the existence of safety plans and sufficient stability within the current living situations of potential clients. In this way, recent incidences of domestic violence within a family home or transitions between foster care or kinship care placements act as exclusionary criteria for access to this service. In addition to the specific psychological assessment and intervention provided by this service of the state health department, and outlined below, clients are also referred externally to other agencies for specialist interventions, including psychiatric services, speech-language therapy, and occupational therapy.

This state-wide service was birthed from the Wood Royal Commission report of 1997, which investigated paedophilia in New South Wales and found a lack of services for offending parents. At its inception, this service employed a sole Senior Counsellor, with an additional 4.5 equivalent counsellors added shortly thereafter. With eleven such services state-wide, the particular service represented in this study reports currently employing the equivalent of 5.5 counsellor/case workers, 2.5 of whom are registered psychologists and 4.2 social workers. In addition to these professionals, an Intake Manager oversees the case load of the service, provides early intervention services and acts as a representative for the service at initial family visits with a state child welfare department case worker. The psychologists employed by

this agency have two main roles; counsellor and caseworker. In their work as counsellor, psychologists initially engage in a three month assessment period with each client, during which time data is gathered from a myriad of informants, including parents, carers, teachers and school counsellors, professionals from community organisations already involved with a case, and both historic and current child protection documents. Following this assessment period, psychologists are then involved in planning and implementing interventions that may consist of therapeutic work with biological parents, carers, or entire families and/or group work with other children and young people. As caseworkers, psychologists within this agency attend regular three-monthly meetings with relevant staff from the state child welfare department, provide consultation and training to staff within the state health department, and deliver practice forums, which target pertinent issues in working alongside child welfare clients, such as the impact of trauma on child development.

In addition to the service of the state health department described above, an alternate service from the same department in New South Wales was also included in this study. Within this specialist Child and Adolescent Mental Health Service, referrals are received from both the state child welfare department and various health centres located within the geographical area covered by the governing area health service. In order to meet criteria for psychological services within this agency, the children and young people who are being referred must be aged 3-18 years, exhibit high needs, such as severe behaviour and/or emotional difficulties, and be of significant concern to the professionals making the referral. The psychological assessment and intervention provided by this service is relatively comprehensive; however, on occasion clients are referred internally to specialist programmes. Furthermore, because all children and young people who enter this service have

previously been, or are currently involved with other agencies, communication with such agencies, including the sharing of relevant information, takes place on a regular basis.

This service was established approximately eight years ago after concerns were raised about the increasing number of crisis presentations involving behavioural and emotional issues at the Emergency Departments of local hospitals. Initially, the service began with a psychiatric clinic which was in operation for half a day every fortnight. This gradually increased by an additional day a fortnight and with it, the inclusion of an allied health professional. Approximately three years ago several more full-time positions were established, which extended the service to its current position. Presently, the team of professionals operating this service includes three part-time psychiatrists, three health clinicians, two clinical health psychologists, two registered psychologists seconded from the state child welfare department, one social worker, and finally, an intern psychologist on a six month rotation also from the state child welfare department. In addition to these permanent team members, a specialist neuropsychologist visits the service once a week to undertake specialist neuropsychological assessments. Within this team, the two clinical health psychologists hold most of the responsibility for providing psychological services to clients within this agency. Their role includes working with around 10 clients, holding individual appointments with these clients, in addition to visiting homes, schools and other agencies involved with clients, engaging in frequent e-mail communication with case workers from the state child welfare department, schools, and other relevant professionals, attending a weekly team meeting and delivering weekly half-day training groups to foster carers.

*Non-government organisations with in-house psychological services*

The non-government organisations delivering in-house psychological services included in this study are characteristic of the diversity of such services provided to child welfare clients throughout New South Wales. The criteria for accepting referrals to the psychological services within these organisations ranges from exclusive service contracts with the state child welfare department to more flexible policies allowing for potential clients to be referred by other community agencies or from concerned members of the general public. Among organisations with the latter criteria, intake assessments are often completed upon a client's initial contact with the agency in order to determine the level of service needed, if any. Within other organisations, the enforcement of exclusionary criteria means that children and young people with significant physical or intellectual disabilities, drug addiction or extreme violent behaviour are not eligible for psychological services provided by such organisations. In addition to these in-house psychological services, each organisation also reports utilising other services by externally referring clients for specialist assessment or intervention. Such services include the state child welfare department; in addition to both state and non-government organisations working alongside individuals with physical and intellectual disabilities and community mental health agencies that deliver psychiatric services (e.g. the prescription of psychotropic medication) to their clients.

Among the non-government organisations determined to provide in-house psychological services to child welfare clients in New South Wales, the age of such services also varies greatly. The earliest service established among these organisations began operating around 20 years ago, another, approximately 10 years ago, while the remaining three services represent fairly recent additions to the



provision of psychological services for child welfare clients; 20 months and 9 months in operation. Each of the services included in this study represent the New South Wales state branch of larger, national organisations, which have been working alongside vulnerable populations (not necessarily child welfare clients) for many decades.

The size of the psychological services within each of these organisations also varies, from a single psychologist in two organisations to a team of nine psychologists across two sites in another. The remaining two organisations employ two psychologists and six psychologists, respectively. Among all non-government organisations delivering in-house psychological services, psychologists also represent different stages of career development, with the majority of such professionals working as fully registered psychologists and four as intern psychologists among these organisations. Given the diversity within the structure of such services and the experience of the professionals working within them, the roles of psychologists working in non-government organisations across New South Wales is likewise varied. The function of the psychologists among these organisations includes engaging in psychological assessment, such as developmental and cognitive assessments, planning behavioural interventions, undertaking individual counselling or group work with children and young people, attending case conferences and other relevant multi-disciplinary meetings, providing training and psychoeducation to other staff members in addition to foster carers, and in some cases, managing and developing the psychological services within the agency.

*Non-government organisations without in-house psychological services*

As was found among non-government organisations that provide in-house psychological services to child welfare clients, the majority of organisations without such services also report receiving referrals directly from case workers within the state child welfare department. In addition, several organisations also cited accepting community referrals from other non-government agencies and concerned members of the general public. Given the fact that each of these organisations does not provide in-house psychological services to child welfare clients, the practice of making referrals to alternate agencies is commonplace among such organisations. The referral practices among these organisations vary considerably. Psychological services provided by state child welfare and health departments are primarily utilised by these organisations, in addition to other community-based agencies and private practitioners.

The majority of non-government organisations without in-house psychological services represented in this study are reportedly satisfied with the current process of externally accessing such services for clients within the agency. Furthermore, open-ended discussion facilitated by the researcher revealed that limited access to funding was the overwhelming contributing factor in preventing such organisations from developing in-house psychological services of their own. Only one organisation from New South Wales declared plans to develop such a service for child welfare clients. This organisation, which is responsible for sourcing suitable foster care placements for children and young people referred from the state child welfare department, was advertising a vacant position for an in-house psychologist at the time of data collection in late 2009.

**Western Australia**

According to the information obtained from the state child welfare department in Western Australia, no formal criteria are employed by this department in selecting clients for psychological services. Rather, children and young people are referred for such services by social workers or 'welfare officers', who work collaboratively with psychologists in the department as part of a multidisciplinary team. This department reports that the psychologists within this department are often be involved with various cases in the initial stages of contact with this state child welfare department that ultimately cross their path when they are internally referred for psychological services. In this way, psychologists are instrumental in ensuring that the children and young people most in need of psychological services are referred to the appropriate professionals within this department.

This state child welfare department provides an extensive in-house psychological service for clients who are determined to be in need of such services, through the avenues outlined above. In addition to this in-house service a collaborative partnership with the state health department also exists, such that clients are referred to local Child and Adolescent Mental Health Services by psychologists within this state child welfare department when deemed necessary or beneficial. In addition to this partnership with the state health department, this department also utilises a list of approved registered psychologists who deliver services from private practices throughout the state. These private practitioners are often reserved as a last resort, however, given the cost of accessing such professionals for clients within the state child welfare department.

This department originally began as a welfare service exclusively for aboriginal clients and has since evolved into a service for all child welfare clients in

Western Australia. The department currently employs approximately 45-50 psychologists who work in various capacities throughout the state in both rural and urban centres. These psychologists are located in numerous local offices across Western Australia, in addition to specialised placements in Residential Care Facilities and Fostering Services. Among these placements, psychologists are currently employed in five of a possible seven positions in Residential Care Facilities and in the maximum four positions in Fostering Services. All other psychologists are based in local offices throughout the state.

While the psychologists employed by this state child welfare department are found in relatively diverse roles, the practical work undertaken by such professionals on a daily basis is largely streamlined across the department. With a typical caseload of around 10 clients, psychologists within this department are involved in both assessment and intervention with the children and families in their care. Specifically, these psychologists engage in supporting the child and foster carers through out-of-home placements, conducting parenting capacity assessments with the biological parents of the children and young people in care, providing individual play therapy focussing on the experience of trauma and abuse for the child, consulting with other department staff members on the best way to receive and refer clients, and attending meetings with other specialist professionals, such as in the Early Intervention team.

### **Queensland**

As in Western Australia, the organisations included in this study from Queensland provide an incomplete picture of the provision of psychological services to child welfare clients in this state. Within this state, information was only obtained for non-government organisations that do not include in-house psychological

services. One such organisation reports accepting clients exclusively from the state child welfare department in Queensland, while the other accepts referrals from this department in addition to referrals from professionals working in other community agencies. Neither organisation reports currently employing psychologists to deliver psychological services to clients, instead referring children and young people determined to have a need for such services to the specialist psychological service of the state child welfare department. As in the case of the state child welfare department in Western Australia, clients were also referred by these non-government organisations to services provided by the state health department (Child and Youth Mental Health Services in Queensland). One organisation reports employing professionals in 'specialist positions' who are responsible for conducting an initial needs assessment, oftentimes resulting in a referral to the state child welfare department, in addition to case planning; however none of these roles were filled by psychologists.

Among the non-government organisations from Queensland, differing views exist with regard to the development of in-house psychological services. One such organisation, which already employs professionals in specialist positions, does not perceive a need for psychologists, as the close partnership with the specialist psychological services provided by the state child welfare department means child welfare clients within this organisation are receiving such services through other avenues. According to this organisation, the professionals employed in specialist positions provide adequate needs assessment and case planning, such that the employment of psychologists would be deemed surplus to requirements. In the alternate non-government organisation, however, a recent review of mental health

service provision to clients within this organisation has seen the employment of an in-house psychologist due to commence work in early 2010.

Upon speaking with a former Principal/Senior-Regional Psychologist of within the Queensland state child welfare department, further information was obtained as to the structure and delivery of such services throughout the state. The current Director of such services was also contacted and presented with an opportunity to serve as a respondent in this project; however, contact was not made with the researcher within the allocated time frame. This specialist psychological service, alluded to by the non-government organisations from Queensland included in this study, is a joint initiative by three state government departments that are charged with the delivery of child welfare services to children and young people who display high and complex needs. Specifically, this service is a partnership between the state child welfare, health and education departments in Queensland. Together, these government departments provide therapeutic and behavioural support services to child welfare clients who are on custody or guardianship child protection orders from the state child welfare department. Such clients may also be placed in out-of-home care and display severe emotional and/or behavioural difficulties, or specific physical and/or intellectual disabilities.

These therapeutic and behavioural support services are provided by 29 multidisciplinary teams throughout the state, comprising of psychologists, speech-language therapists and occupational therapists. There are currently plans to extend these services to include nine additional multidisciplinary teams in Brisbane and South West Queensland; however the exact number of psychologists working within these teams was not obtained. The professionals working within such teams are involved in conducting an initial comprehensive assessment spanning 10 domains,

including biological, psychosocial and cultural assessments. In this way, the specialist psychological services provided by the state child welfare department work collaboratively with child safety officers, family, foster carers, schools and non-governmental organisations in order to provide medium to long-term interventions that seek to improve a child or young person's functioning and consequently increase stability in out-of-home placements, to increase school involvement and to enhance a child or young person's engagement in community activities designed to assist in their development and wellbeing.

### **Cross-jurisdiction comparison**

The most comprehensive information obtained in this study was collected from government child welfare and health departments, and non-government organisations from New Zealand and New South Wales; jurisdictions that comprised 30.8% and 53.8% of respondents, respectively. Because the most comprehensive data were obtained from these geographical locations, the opportunity to compare services across locations is limited to a comparison of these two child welfare jurisdictions. The incomplete nature of the data compiled from Western Australia and Queensland means that a comprehensive picture of the provision of psychological services within these states cannot be reported here. Similarly, with no data for the remaining five Australian states and territories, the nature of psychological service provision to child welfare clients in these jurisdictions cannot be described.

Among the jurisdictions for which comprehensive data were obtained, psychological services provided by the national child welfare department of New Zealand were described in considerable detail. Such services comprise of 20

psychologists located among four SSUs throughout the country. These psychologists are responsible, to varying degrees, for the assessment of children, young people and their families and for the implementation of psychological intervention with these individuals. The provision of training and psychoeducation to other staff members is also of central importance to the role of such professionals. Information was also obtained as to the nature of psychological services provided by non-government organisations that hold service contracts with the national child welfare agency. The psychologists working within such organisations are determined to have similar professional responsibilities to those employed by the government child welfare agency of New Zealand. The process of referring clients externally for psychological services is also similar among all agencies from New Zealand included in this study. The predominant referral process utilised by the national child welfare department in addition to non-government organisations both with and without in-house psychological services is to refer clients with significant mental health needs to such services provided by local District Health Boards in respective regions of the country.

Both state and non-government organisations working alongside child welfare clients together provided a comprehensive picture of psychological service delivery to these vulnerable child and young people throughout New South Wales. With a team of 65 psychologists working in various regions across New South Wales, the state child welfare department is the largest provider of psychological services to child welfare clients. These psychologists engage in psychological assessment and intervention, in addition to working as part of multidisciplinary teams both within and outside of the department. Such professionals also undertake regular training sessions in which department staff and foster carers alike are



provided with relevant psychoeducation and advice on how best to meet the needs of the children and young people in their care. In addition to these psychological services, clients of the state child welfare department are also referred to non-government organisations via service contracts with this department. A close partnership between the state child welfare and health departments in New South Wales sees the sharing of psychologists who spend a period of time working in each. Furthermore, non-government organisations located in this state also report a collaborative relationship with services provided by the state health department, in which clients are referred to such services for psychological assessment and/or intervention.

Information with respect to the provision of psychological services to child welfare clients in Western Australia and Queensland was sufficiently limited that a comprehensive picture of such services could not be described for these states. What is reported, however, are the psychological services of the state child welfare department in Western Australia and several accounts of non-government organisations that do not comprise of in-house psychological services in Queensland. In the former, reports indicate that approximately 45 psychologists provide psychological services to clients within the state child welfare department of Western Australia. In addition to such services, which include psychological assessment and intervention, the contribution of specialist knowledge to multidisciplinary meetings and the provision of psychoeducation and practical training to department staff, clients are also externally referred to services of the state health department. Among the non-government organisations from Queensland that do not comprise of in-house psychological services, clients are alternately referred to psychological services jointly provided by the state child welfare, health and education departments. It

should be remembered that the information obtained from the Australian states of Western Australia and Queensland only describes the specific services included in this study and not a complete picture of the delivery of all psychological services to child welfare clients in these jurisdictions.

Table 2. *Nature of Psychological Services among Government Child Welfare Departments across Jurisdictions*

	<b>NZ</b>	<b>NSW</b>	<b>WA</b>	<b>QLD</b>
<i>No. of substantiations from child protection notifications</i>	20,560	34,078	1,523	7,315
<i>No. of children in OOHC</i>	4,503	13,566	2,546	6,670
<i>No. of psychologists in child welfare department</i>	20	65	45	-
<i>Ratio of child protection substantiations to psychologists</i>	1028:1	524:1	34:1	-
<i>Referral to CAMHS?</i>	√	√	√	√
<i>Contracted psychological services (fee-for-service)?</i>	√	-	√	-

NZ: New Zealand, NSW: New South Wales, WA: Western Australia, QLD: Queensland, OOHC: Out-of-home-care, CAMHS: Child and Adolescent Mental Health Services -: not available.

Table 2 provides a summary of the data collected in this study, combined with pertinent information obtained from recent reports describing critical statistics among child welfare services in New Zealand and Australia for the 12 month period to June 30, 2008 (Ministry of Social Development, 2009; Australian Institute of Health and Welfare, 2009). As is illustrated in this table, the smallest ratio of child welfare clients to psychologists is found in the state child welfare department of Western Australia, followed by New South Wales and New Zealand. This ratio could not be calculated for Queensland however, as information pertaining to the number

of psychologists employed by this state child welfare department was not available. Also highlighted here is the close partnership between the government child welfare and health departments in each jurisdiction, as evidenced by the by the incidence of referring clients externally to Child and Adolescent Mental Health Services by all child welfare departments across the board. Contracting private practitioners to provide psychological services to clients is a practice that is not so widely utilised by child welfare departments throughout Australasia.

### **Discussion**

The results of this study shed significant light on the provision of psychological services to child welfare clients in Australasia, particularly in New Zealand and New South Wales. The relatively high level of agreement between respondents in this study with regard to information obtained from the various jurisdictions throughout Australasia engenders confidence in the accuracy of the picture of psychological service provision developed from such data. While important differences are found in the structure and scope of such services delivered to child welfare clients by government child welfare departments and non-government organisations alike, such differences merely highlight the lack of a ‘best practice’ model consistently employed by such agencies throughout New Zealand and Australia. Throughout New Zealand and New South Wales, locations in which the most comprehensive data were obtained, there does not appear to be sufficient evidence to suggest that a single model of psychological service provision is utilised by agencies either within, or across these jurisdictions. Among the government child welfare and health departments, and non-government organisations included in this

study, significant variation exists in the structure and scope of psychological services provided to child welfare clients.

With regard to the structure of such services, distinctions are found in the number of psychologists working with child welfare clients determined to be in need of mental health assessment and/or intervention, the location of such professionals within various government departments and non-government organisations, and to some extent, the overall role of psychologists within such agencies. Often as the result of funding limitations, the number of psychologists found within any given psychological service varies considerably and ranges from sole-charge psychologists to teams comprising of a dozen or more such professionals. The physical location of psychologists within government departments and non-government organisations across New Zealand and New South Wales is also relatively diverse. Among a number of psychological services these professionals are situated in teams with other psychologists, while in alternate services psychologists are distributed across a number of sites and work as part of multidisciplinary teams. Furthermore, the role of psychologists often varies depending on their location within a service. Generally, psychologists who fulfil their professional responsibilities in sites comprising of like-minded professionals utilise a more ‘hands-on’ approach in the provision of psychological services to child welfare clients. Psychologists who serve as part of multidisciplinary teams, however, often find themselves fulfilling a more consultative role in the delivery of such services.

Distinctions in the scope of psychological service provision also lend support to the argument that a uniform model of ‘best practice’ is not widely utilised by government departments and non-government organisations providing psychological services to child welfare clients throughout Australasia. Such differences are found

in the nature of clients and geographical locations serviced by these agencies, in addition to the scope of psychological assessment and intervention provided to such clients. Within these agencies, numerous referral criteria are utilised such that some non-government organisations accept clients exclusively from the government child welfare department, while others employ more flexible criteria that include clients referred by other community organisations and concerned members of the general public. In addition, these agencies also vary in the geographical location in which they provide psychological services. A number of agencies are based in large urban centres, while others service rural populations of child welfare clients, and others still service both urban and rural geographical areas. To a lesser extent, differences are also found in the scope of psychological assessment and intervention provided to child welfare clients, with the majority of government departments and non-government organisations delivering both services and a small number of non-government organisations focussing on assessment only or limiting the nature of interventions by excluding work with the biological parents of these vulnerable children and young people.

The present lack of a 'best practice' model among government child welfare and health departments, and non-government organisations throughout Australasia is due in part to the corresponding lack of consensus among these agencies regarding what such a model would practically look like. In their current state of provision, psychological services take on numerous different forms that are largely determined by the governing philosophy of individual agencies. Further research is required in this area, particularly in New Zealand and Australia, before such a model can be developed and applied to the provision of psychological services to child welfare clients.

**Psychological services in context**

Before turning to a discussion of the various differences and similarities between the provision of psychological services to child welfare clients in New Zealand and New South Wales, it is important to first outline the context in which such services currently exist. The dramatic increase in the number of notifications made to the government child welfare departments within each jurisdiction in recent years has resulted in a corresponding rise in the number of children and young people placed in out-of-home care. Within New Zealand, the number of care and protection notifications received by the national child welfare department has risen significantly in the past five years, from 40,939 in the year to June 2004 to 89,461 in the same period to June 2008 (Ministry of Social Development, 2009). A similar trend is found in the Australian state of New South Wales, where notifications to the state child welfare department have increased from 115,541 in the year to June 2004 to 195,599 in the same period to June 2008. Consequently, the number of children and young people in out-of-home-care has also risen during this five year period, from 9,145 year to June 2004 to 13,566 in the same period to June 2008 (Australian Institute of Health and Welfare, 2009).

With such dramatic increases in the number of children and young people brought to the attention of government child welfare departments in Australasia in recent years, it is essential that the size of psychological services within such jurisdictions also expand in order for the mental health needs of such individuals to be met. Unfortunately, to the researcher's knowledge this has not been the case. While the data presented here regarding the trend towards an increase in the number of child welfare clients across Australasia focuses on the past five years, this pattern has been in operation for around 10 years. During this time the development of in-

house psychological services by child welfare departments in New Zealand and New South Wales has been disproportionate in relation to the number of care and protection notifications received by such departments. In order to adequately meet the needs of such individuals, a radical overhaul of psychological services within these child welfare departments must be completed with some sense of urgency.

### **Comparison of New Zealand and New South Wales**

While the breadth of information obtained during the course of this study is not as comprehensive as initially anticipated, the outline of psychological services within New Zealand and New South Wales nevertheless provides a good foundation from which to evaluate such services for child welfare clients. In utilising the descriptions of psychological services within various agencies working alongside this vulnerable population in New Zealand and New South Wales it is possible to compare and contrast the provision of such services in each jurisdiction. Furthermore, because the populations within these locations are reasonably close in number, 4.31 million and 6.98 million respectively, a direct comparison of the provision of psychological services to child welfare clients can effectively be made. While this may be the case, it is important to note that given the Australian state of New South Wales has a larger population than that found in New Zealand it is expected that, to some extent, the size and number of psychological services provided to child welfare clients will be correspondingly larger in the former.

### *Differences*

In conducting a brief overview of the nature and scope of psychological services for child welfare clients in New Zealand and New South Wales, it is soon

apparent that a number of significant differences exist between the two. Such key differences are found in the number of psychologists employed by each government child welfare department and the location of such professionals, the number of non-government organisations servicing the psychological needs of child welfare clients, and the perceived need for and importance of evaluations of child protection services, including psychological services, commissioned by each government.

Perhaps the most striking of such differences is the discrepancy in the number of psychologists employed by the respective government child welfare departments in New Zealand and New South Wales. Within the former, approximately 20 psychologists are employed in four Specialist Service Units (SSUs) operated by the national child welfare department across the country. These units, located in Auckland, Tauranga, Waikato and Christchurch, vary greatly in the size and scope of practice between each geographical location. The unit situated in central Auckland, and indicated by respondents in this study as the most functional of such services, employs the greatest proportion of psychologists within the department, at 13 full-time equivalent registered and intern psychologists. The remaining seven psychologists employed by the New Zealand child welfare department are spread among Tauranga, Waikato and Christchurch SSU locations.

The situation within the South Island of New Zealand is the most grim, with a single SSU located in Christchurch; a service that employs one 0.8 equivalent psychologist. Statistics highlighting the disparity between the provision of psychological services to child welfare clients in the North versus South Islands of New Zealand further illustrate just how under-resourced this southern population is. It is well known among professionals familiar with the geographical distribution of child welfare clients throughout the country that a large proportion of such clients are



located in the North Island of New Zealand. Despite this fact, there still exist a disproportionate number of psychologists providing psychological services to members of this vulnerable population in the South Island of New Zealand. With around 25% of the nations' total children and young people in care, the South Island's lone psychologist serves these child welfare clients at a ratio of around 1,830 to 1. Compare that to the ratio of children and young people in care to psychologists in the North Island, 222:1, and the mismatch between psychological service need and provision with regard to geographical location becomes abundantly clear ( F. Kney, personal communication, February 11, 2010). Furthermore, across the entire country, the ratio of children and young people with substantiated investigations of maltreatment to psychologists within the national child welfare department is estimated at around 1028:1.

Within the child welfare department of New South Wales, however, a very different situation is found. Conservative estimates suggest that this department employs approximately 65 psychologists who work in different capacities throughout the state. Furthermore, with around seven psychologists located in each of the service centres across the seven regions of New South Wales, the distribution of such professionals to child welfare clients throughout the state is considerably more even than that demonstrated in the New Zealand child welfare department. In placing psychologists at service centres within each of the seven regions across the state, the New South Wales child welfare department allows its in-house psychological services to be effectively accessed by all children and young people in care. In addition, by distributing psychologists relatively evenly throughout the state, a situation whereby a small number of such professionals are responsible for the

provision of psychological services to a large proportion of child welfare clients is avoided.

The total ratio of child welfare clients to psychologists within the New South Wales child welfare department is also healthier than that of the corresponding department in New Zealand. With approximately 34,078 children and young people with substantiated investigations of maltreatment across the state (Australian Institute of Health and Welfare, 2009) and the employment of approximately 65 psychologists, the ratio of child welfare clients to psychologists for all of New South Wales is calculated at 524:1. Compared to the New Zealand estimate of child welfare clients to psychologists, which was calculated at 1028:1, it appears that psychological services within the New South Wales child welfare department are greater resourced, in terms of the employment of psychologists, than their New Zealand counterparts.

Furthermore, differences are also found between the location of such professionals in New Zealand and New South Wales. For the most part, psychologists employed by the national child welfare department in New Zealand are located in teams at specialist clinics, known as SSUs. The exception is of course in the Christchurch unit, where the sole psychologist comprising of this service is physically located in the same building as a team of social workers and other professionals. The result of such units is a close professional community of psychologists that are oftentimes difficult to access for the vast majority of social workers and their clients. With regard to the situation in New South Wales, however, the opposite is true. Throughout the seven regions that comprise this state, psychologists are largely located in local service centres among a team of social workers and other professionals. Thus, psychological services are relatively

accessible to social workers and their clients, while psychologists can feel somewhat isolated in their work with these vulnerable children and young people.

In addition to the differences outlined above, the number of non-government organisations servicing child welfare populations in New Zealand and New South Wales is also disparate. An investigation of the agencies included in this study reveals a far greater number of such organisations in the state of New South Wales, as compared to New Zealand. Respondents residing in the former represented eleven different non-government organisations, while respondents from New Zealand represented just four different non-government organisations. Specifically, respondents from such organisations located in New South Wales consisted of five Principal Psychologists and six Directors of agencies working alongside child welfare clients across the state. In New Zealand, this same category of respondents comprised of two Principal Psychologists and two Directors of agencies servicing child welfare clients throughout the country. Towards the end of the period of data collection a number of non-government organisations located in New South Wales continued to present as potential respondents in this study, however time constraints meant that professionals within such agencies could not be contacted for interviewing. The situation within New Zealand was considerably different, with all known non-government organisations contacted well before the period of data collection drew to a close. Only one such organisation providing in-house psychological services to child welfare clients in the far south of New Zealand declined to participate in this study.

The incidence of non-government organisations with in-house psychological services is also greater in the state of New South Wales. Five Principal Psychologists representing non-government organisations in New South Wales served as

respondents in this study, compared with just two Principal Psychologists from such agencies in New Zealand. Among the network of professionals working alongside child welfare clients in New South Wales, a significant number of agencies that do not provide psychological services to this vulnerable population of children and young people report referring such clients to other non-government organisations, in addition to private practitioners and the state child welfare and health departments. The practice of externally referring clients for psychological services among non-government organisations in New Zealand is somewhat different. Agencies included in this study without in-house psychological services overwhelmingly reported referring clients to services provided by local District Health Boards throughout the country. Referring clients to other non-government organisations for psychological services was not mentioned by either Director of such agencies in New Zealand. This is perhaps because so few non-government organisations provide such services to child welfare clients, and those that do focus the majority of their resources into mutual clients of the national child welfare department.

A third key difference in the provision of psychological services to child welfare clients in New Zealand and New South Wales is the perceived need for and importance of evaluations of child protection services commissioned by each national or state government, respectively. Recent developments in the delivery of child protection services in New South Wales have seen several significant changes take place in an attempt to ensure that all child welfare clients throughout the state receive the best services available for their unique needs. In 2008, a Special Commission of Inquiry, conducted by retired Supreme Court Judge, the Hon James Wood AO QC, was requested into child protection services in New South Wales following the deaths of two young children who were known to the state child

welfare department (Department of Premier and Cabinet, 2009). Specifically, this report outlined extensive recommendations for restructuring within the state child welfare department through the presentation of eight principles designed to guide the department in providing child protection services to vulnerable children and young people throughout the state. The report, released in late November 2008, was commissioned by the New South Wales government who have since developed an action plan entitled *Keep them Safe: a shared approach to child wellbeing* (Department of Premier and Cabinet, 2009). This plan, based on the recommendations of Justice Wood, was developed with the goal of observing a reduction in the number of children and young people reported to the state child welfare department coupled with an increase in the support of vulnerable families at a community level by government services and non-government organisations.

The key reforms outlined in the Wood Inquiry, as it has come to be known, posit that the state child welfare department should only receive reports of child maltreatment in which children and young people are suspected of being at risk of *significant* harm. All other child protection concerns should be directed towards newly developed units within several state departments, including those charged with the provision of services relating to health, education and training, ageing, disability and home care and juvenile justice, in addition to the New South Wales Police force. In this way, one of the most significant outcomes from this inquiry is the increased role of these departments, particularly the state health department. This shift in the role of government departments with regard to child protection issues may even see a proportion of the work conducted by psychologists within the state child welfare department transfer to psychological services provided by the state health department. These recommendations, which are already being implemented in New

South Wales, will bring with them a significant shift in the way child protection services are delivered to children and young people across the state. Given that the report was released less than 18 months ago, the full effects of this inquiry and the resulting recommendations will not be known for some time.

In New Zealand the promise of a similar inquiry, with a specific focus on the provision of in-house psychological services to child welfare clients, has so far failed to be fully executed. According to several respondents within the national child welfare department, a review of such services was intended to begin in late 2009. The reality, however, is that while this review did commence shortly after its proposed start date, it has since been suspended due to other project priorities. This much anticipated review is scheduled to recommence at a later date in 2010. Despite the shortcomings of the national child welfare department in this respect, an alternate review of the department's four Care and Protection Residences throughout the country has seen the implementation of a clinical model in which two positions for in-house psychologists have been created in the Christchurch residence. The recent addition of such professionals is a positive first step in the development of psychological services for New Zealand child welfare clients.

Why is it that such differences exist between the provision of psychological services to child welfare clients in New Zealand and New South Wales? Evidence contained in the data collected throughout the duration of this study points to several possible explanations for these differences. Firstly, it appears that, in general, there is a greater recognition of the mental health needs of child welfare clients in New South Wales than of similar clients in New Zealand. The existence of a large team of psychologists distributed evenly throughout the state, coupled with a significant

number of non-government organisations working alongside child welfare clients, many providing in-house psychological services to such clients, and the recent inquiry into child protection services in New South Wales suggests that professionals working in this field, and in fact government policy-makers, are aware of the importance of addressing the mental health needs of children and young people in out-of-home care, and indeed all child welfare clients. Armed with the knowledge of the unique needs of this vulnerable population, the New South Wales child welfare department clearly acknowledges the importance of providing psychological services to child welfare clients, not only in the practical sense of employing a number of psychologists and partnering with non-government organisations, but also in the implementation of policies which reflect the priority of effectively meeting the mental health needs of these vulnerable children and young people.

It is possible that the presence of a greater number of psychologists working within the New South Wales child welfare department and health department, in addition to numerous non-government organisations, assists in the promotion of the mental health needs of child welfare clients throughout the state. In this way, psychologists working in various capacities across New South Wales effectively fulfil their role of *advocate* by educating others as to the nature of the behavioural and emotional difficulties experienced by such clients. With so few psychologists employed by the national child welfare department in New Zealand, especially in the South Island, the task of advocating for the provision of psychological services on behalf of clients proves much more difficult.

Further to these possible explanations for the differences in psychological service provision to child welfare clients in New Zealand and New South Wales, it is likely that other contributing factors are at work here. Whatever the case, it is

apparent that several important differences exist between these two jurisdictions, such that the mental health needs of child welfare clients in one country are addressed much more effectively than the other.

### *Similarities*

In addition to these differences, there also exist several important similarities between the provision of psychological services to child welfare clients in New Zealand and New South Wales. Such similarities include the practice of receiving referrals from social workers to psychological services within government child welfare departments, and likewise for non-government organisations, receiving referrals from the government child welfare department and other non-government organisations, the partnership between government child welfare and health departments in both jurisdictions, and the nature of the professional responsibilities of psychologists in New Zealand and New South Wales.

Respondents from government child welfare departments in both jurisdictions reported receiving internal referrals for psychological services directly from a client's social worker or case worker (these terms are utilised interchangeably). In each of the government child welfare departments represented in this study, social workers appear to exercise their own discretion in determining whether a child or young person is in need of psychological services. At times, this decision is reached in collaboration with other individuals such as a client's foster carers, teacher, and paediatrician. In other cases, social workers are solely responsible for making a referral to in-house psychological services. Thus, whether a client is referred for such services or not is largely dependent on an individual social worker's sensitivity to mental health issues in children and young people. This process can become



problematic, however, when social workers are inadequately trained to identify the specific behavioural or emotional difficulties a client may be facing. In this way, the mental health needs of such clients remain largely unmet and can often be compounded by the experience of being placed in out-of-home care, or alternatively remaining in their family home (Newton, Litrownik & Landsverk, 2000). In an attempt to counter such processes, the government child welfare departments in New Zealand and New South Wales reported that the psychologists employed by these departments provide practical training and/or psychoeducation to other staff members, including social workers, as part of their professional responsibilities. This is a crucial aspect of the role of psychologists as they seek to educate other professionals and lay people alike as to the unique mental health difficulties experienced by child welfare clients.

Among non-government organisations in New Zealand and New South Wales, the practice of receiving referrals was likewise similar between the two. Despite their similar referral processes, these organisations varied considerably in their purpose and scope. Several organisations represented local branches of larger national or international agencies committed to working alongside vulnerable populations, such as child welfare clients. Other organisations included in this category were small community-based agencies, with just one or two psychologists providing psychological services to clients.

These organisations, both with and without in-house psychological services, reported accepting at least a portion of all referrals from their respective national or state child welfare department. This practice was somewhat variable across New Zealand and New South Wales, with several non-government organisations receiving referrals exclusively from these departments. In other organisations, referrals were

also received from other community agencies and from concerned members of the general public. Most non-government organisations required evidence of behavioural and/or emotional difficulties in potential clients and many utilised an intake assessment to determine the severity of such difficulties, and consequently, a client's eligibility for involvement with the organisation.

Government child welfare departments in New Zealand and New South Wales also reported similarities in their professional relationship with government health departments, and vice versa. In New South Wales, this relationship is perhaps the strongest, as representatives from both state departments described a close partnership in which multidisciplinary meetings regarding mutual clients are a common occurrence. The sharing of information with reference to these clients is also something that is endorsed by professionals from both departments. Furthermore, one service provided by the state health department in New South Wales outlined a psychological services team of which two psychologists seconded from the state child welfare department were a part. This appears to be a growing practice in this state.

The professional relationship between the national child welfare and health departments in New Zealand is also collaborative in nature. Given that the size and distribution of psychological services within this department is somewhat more limited than that of New South Wales, psychologists working within such services often refer child and young people to services provided by local District Health Boards, namely Child and Adolescent Mental Health Services. The partnership between the national child welfare department and such District Health Boards is perhaps most effective in the city of Auckland, where a joint initiative between these two government services and the New Zealand Police sees the delivery of

psychological services to child welfare clients in the region. In utilising a multi-agency model and physically operating these services from the same location, professionals from each agency work collaboratively, utilising the specialist skills within such a team to deliver comprehensive services to this vulnerable population.

In addition to the partnership between government child welfare and health departments in New Zealand and New South Wales, the relationship is similarly strong between the various non-government organisations working alongside child welfare clients in each of these jurisdictions and services provided by their respective government health departments. In both locations, such organisations report referring clients to local mental health services for additional assessment or intervention. This relationship is often maintained through frequent communication between professionals working in such non-government organisations and psychologists, among other professionals, from services provided by government health departments.

Finally, there exist considerable similarities in the professional responsibilities of psychologists working in government and non-government organisations throughout New Zealand and New South Wales. When asked to describe the role of psychologists within their respective agencies, respondents outlined similar, almost identical, responsibilities undertaken by such professionals on a daily basis. The data collected with respect to these responsibilities can be divided into several key components, including undertaking psychological assessment and intervention, attending multidisciplinary meetings or case conferences and providing agency staff and foster carers with training on pertinent issues with respect to supporting child welfare clients.

Across all agencies included in this study, psychologists regularly engage in psychological assessment of children, young people and their families, such as psychosocial, cognitive or developmental assessments of children and young people themselves, in addition to assessments of attachment and bonding, and parenting capacity, which includes additional family members. Evidential interviewing is also included in the role of psychologists working in the Auckland SSU of the New Zealand child welfare department. Psychologists working alongside child welfare clients also engage in a number of interventions that can take the form of individual work with the child or young person themselves, such as Cognitive Behaviour Therapy or individualised behaviour plans, with other peers facing similar difficulties, or with several family members as in Functional Family Therapy. Another key component of the role of psychologists in New Zealand and New South Wales is the regular attendance at multidisciplinary meetings in which a number of professionals form a collaborative partnership in order to address the needs of mutual clients. Such meetings may take place between professionals within a single agency or from several different organisations. To this end, psychologists serve as advocates for their client's mental health needs and seek to inform such professionals as to how these needs may best be met. Finally, respondents working in both jurisdictions report the provision of psychoeducation and practical training to other staff members and foster carers as central to their role as psychologist. Such training may take place in a formal setting where pertinent issues for child welfare clients are the focus, or in the form of informal consultation and advice, in which the needs of specific clients are discussed.

**Lessons to learn**

Given the above discussion of the differences and similarities among the provision of psychological services to child welfare clients in New Zealand and New South Wales, it is important to determine what each jurisdiction can learn from the other. In highlighting the respective strengths among these services in each location it is possible to derive key lessons that can be applied from one country to the other. A brief overview of psychological service provision to children and young people involved with child welfare services in New Zealand and New South Wales reveals a number of significant differences which point to the fact that such services appear far more developed in the latter. Thus, the majority of lessons that can be learnt from this investigation of the provision of psychological services to child welfare clients are from New South Wales to New Zealand. Despite this, the operation of such services in New Zealand does have some valuable offerings for New South Wales.

With a government child welfare department employing approximately 65 psychologists working in various capacities and regions throughout the state, health department services and numerous non-government organisations providing similar psychological services to child welfare clients, New South Wales is perhaps one of the best resourced jurisdictions in Australasia. In addition, it appears that the unique needs of this vulnerable population are well recognised by the various professionals charged with promoting the wellbeing of child welfare clients. A recent review of child protection services in New South Wales, including psychological services, suggests that this recognition stretches as far as the politicians working within the state government (Wood, 2008). While such services are not without their flaws, it is likely that child welfare clients would nevertheless benefit from the replication of similar services in New Zealand.

*From New South Wales to New Zealand*

There exist several amendments which could be made to the provision of psychological services for child welfare clients in New Zealand in order to match the level of service described for similar clients in New South Wales. Such amendments include the addition of several psychologists to the national child welfare department, the promotion of psychological services within non-government organisations in order to effectively meet the needs of child welfare clients in New Zealand and the completion of a review of psychological services within the national child welfare department, including clear, practical recommendations for the development of such services throughout the country.

With regard to the number of psychologists employed by the national child welfare department in New Zealand, the current national ratio for children and young people with substantiated investigations of maltreatment to psychologists is estimated at 1028:1, compared to a ratio of 524:1 in New South Wales. In order for the New Zealand child welfare department to match the ratio of child welfare clients to psychologists found in New South Wales, an additional 19 psychologists would need to be employed by this department, bringing the total to 39 such professionals working within the national child welfare department across New Zealand.

Furthermore, placing additional psychologists within the Christchurch SSU and perhaps establishing another unit in the South Island would aid in addressing the disparities between the provision of psychological services to child welfare clients in the North and South Islands of New Zealand. Given that approximately 25% of the nation's child welfare clients reside in the South Island, the employment of seven psychologists within SSUs in this region of the country would see a corresponding proportion of such professionals serve this vulnerable population. While it is not

necessary for psychologists to be employed exactly in the manner outlined above, this proposed model of the distribution of psychologists throughout New Zealand would go some way towards addressing the apparent need for additional psychological services in the South Island.

Another component of the provision of psychological services to child welfare clients in New South Wales that would likely benefit this population in New Zealand is the large number of non-government organisations providing such services to this vulnerable population. Throughout New South Wales a considerable number of agencies receive referrals from the state child welfare department, in addition to other community organisations, for clients who require psychological assessment and/or intervention in order to meet their mental health needs. These organisations primarily operate small in-house psychological services in which a handful of psychologists work as part of multidisciplinary teams serving child welfare clients across the state. The collaboration between these organisations and the state child welfare department, in addition to government health services, is such that children and young people who are in contact with these organisations have a greater likelihood of receiving the services they require.

Within New Zealand, only three non-government agencies providing psychological services to child welfare clients were identified by the researcher (one chose not to participate in this study). While other such organisations may exist throughout the country, the fact remains that the number of non-government psychological services in this country is significantly less than that found in New South Wales. When these services work in partnership with government departments, such as child welfare and health, the streamlined delivery of psychological services that often results is largely beneficial for those child welfare

clients who experience behavioural and/or emotional difficulties. It is hopeful that as an awareness of the unique mental health needs of these clients continues to grow throughout New Zealand, so too will the number of psychological services on offer for this vulnerable population.

In addition to the proposed amendments outlined above, and based upon the provision of child welfare services to clients in New South Wales, the importance of regular reviews and the subsequent development of such services in New Zealand is another lesson that can be learnt from these Australian counterparts. The commissioning of an Inquiry into Child Protection Services in New South Wales by the state government in 2008 was an historical and influential move towards the development of such services in this Australian state. Given that the needs of child welfare clients in New South Wales is an obvious priority for the state government, an inquiry was undertaken, recommendations proposed and an action plan for the implementation of such proposals developed all within a 24 month period. The resulting outcomes from this inquiry will likely increase the effectiveness with which psychological services, and indeed all child welfare services, are delivered to some of the state's most vulnerable children and young people. Only time and further evaluations of such services will tell just how effective these changes have been.

In New Zealand, the review process is currently several steps behind that conducted in New South Wales. While a review of psychological services within the national child welfare department was commissioned and began in late 2009, progress has since ceased due to other project priorities. This much-anticipated review is essential for the development of such services and without it, there exist some uncertainty as to the adequacy or effectiveness of the services currently provided to child welfare clients in New Zealand. Despite the limited progress on



this review to date, the national child welfare department has made assurances that this project will recommence later in 2010. One can only hope that this is the case and that the recommendations developed from this review serve to enhance the delivery of psychological services to child welfare clients throughout New Zealand. A promising sign that the provision of such services is increasingly becoming a priority within the national child welfare department is the recent creation of in-house psychological services within one of the departments' four Care and Protection Residences.

Given the differences cited between the provision of psychological services to child welfare clients in New Zealand and New South Wales and the lessons outlined above, it appears that the former has some way to go before providing comprehensive services to the nation's child welfare clients. In summary, it can be argued that many shortcomings of the New Zealand child welfare department, and beyond, stem from the poor recognition of the mental health needs of this vulnerable population. With fewer psychologists employed by the national child welfare department and fewer non-government organisations delivering psychological services to child welfare clients than in New South Wales, all evidence points towards a lack of acknowledgement of the unique needs of these children and young people by the majority of professionals working alongside such individuals in New Zealand. Unfortunately, this situation is not helped by the employment of so few psychologists by the national child welfare department, especially in the South Island. Without a large body of such professionals to advocate for the mental health needs of child welfare clients it is difficult to promote these needs effectively. Thus, the presence of a limited number of psychologists within the national child welfare department operates as part of a cycle in which such professionals are restricted in

terms of number in their ability to advocate for the mental health needs of child welfare clients. In this way, with such needs largely unrecognised by other professionals and policy-makers, the development of psychological services that effectively address the needs of such clients is not considered a priority. In order for the effective delivery of psychological services to take place in New Zealand, it is critical that the proposed review of such services is made a priority and completed with some urgency. The resulting recommendations should also reflect the unique needs of child welfare clients and should be implemented in a manner that best serves this vulnerable population.

#### *From New Zealand to New South Wales*

The application of lessons from New South Wales to New Zealand is not completely one-sided, however, as the delivery of psychological services within the latter, specifically the Auckland SSU operated by the national child welfare department, is a model that can be readily applied to New South Wales. The multi-agency model employed by this unit has led the Auckland SSU to earn the title of most functional unit in the country. A joint initiative by the national child welfare department and child abuse units of the local District Health Board and the New Zealand Police, the Auckland SSU provides a number of psychological assessments and interventions, including an evidential interviewing unit, for vulnerable children and young people residing in the greater Auckland and Northland regions. With a staff of 27, including 13 psychologists, this unit represents a highly effective collaborative model of psychological service provision, especially as all three agencies are located on one site.

While the overall provision of such services to child welfare clients in the Australian state of New South Wales appears to be largely effective, the existence of a multi-agency model, such as that described above, is something that could enhance such a service further. Similar models are employed in joint initiatives by the state departments of child welfare and health in which a close partnership between these departments is influential in seeing many vulnerable children and young people receive the services they require. The addition of several more sites based on this multi-agency model throughout the state of New South Wales would likely increase the effectiveness with which psychological services are delivered to child welfare clients. Furthermore, the inclusion of the state Police in such a model, particularly when an evidential interview is a part, would likewise assist in the delivery of such services. In this way, communication between state departments is heightened and a collaborative partnership between each of the agencies involved works to streamline the provision of psychological services to child welfare clients throughout the state.

### **Limitations of the study**

While this study remains the first of its kind and a valuable comparison between the provision of psychological services to child welfare clients in New Zealand and New South Wales, it is not without limitations. Firstly, this relatively humble project does not provide a comprehensive overview of such services in Australasia, as initially intended. The data collected with respect to agencies located in New Zealand and New South Wales provides the most detailed description of the delivery of psychological services to child welfare clients within these two countries, however, data collected from the remaining seven Australian states is either non-existent or limited at best.

Secondly, the findings from this study are limited in their representation of agencies within each jurisdiction. The information obtained from Western Australia and Queensland describes exclusively the organisations included in this study and is sufficiently limited that conclusions cannot be drawn as to the provision of psychological services to child welfare clients across the entirety of each state, respectively. Although additional potential respondents were contacted in the majority of the Australian states, time limitations meant that these professionals were not included in the final presentation of data.

Thirdly, time constraints also prohibited the recruitment of psychologists employed by local District Health Boards in New Zealand. With the vast majority of non-government organisations, in addition to the national child welfare department, referring clients to mental health services provided by such health boards, the inclusion of such professionals would have strengthened the data describing the provision of psychological services to child welfare clients in New Zealand. From the information collected in this study, it appears that psychologists working within local Child and Adolescent Mental Health services provide specialist psychological services to a significant proportion of these vulnerable children and young people.

Finally, in addition to the limitations outlined above, the findings of this study are restricted by the design of the interview utilised to obtain pertinent information as to the provision of psychological services for child welfare clients in Australasia. While the questions contained within this semi-structured interview served their purpose well in eliciting valuable information from the respondents in this study, its structure of four core topics of interest meant that the majority of the corresponding data was likewise limited to these topics. This issue was addressed via

the inclusion of a period of open-ended discussion facilitated by the researcher; however, such discussion did not guarantee the addition of valuable information.

### **Status of the study**

Given the high prevalence rates of mental health difficulties among child welfare clients, and the absence of research pertaining to the provision of psychological services designed to address such difficulties for this vulnerable population, the researcher considered it imperative that a study investigating such issues be conducted. This study intended to map psychological services for child welfare clients in Australasia. Specifically, it aimed to a) provide an overview of the scope of child welfare psychological services within the Australian states and New Zealand b) compare and contrast the provision of such services within the Australian states and New Zealand, and c) examine the role of psychologists in non-welfare agencies, such as health and education. In conducting interviews with Principal/Senior-Regional Psychologists and Directors of agencies working alongside child welfare clients throughout Australasia, this study was designed in to elicit pertinent information with regard to the nature and scope of psychological services provided to this vulnerable population.

The findings of this study highlight the apparent absence of a uniform ‘best practice’ model among government child welfare and health departments, in addition to non-government organisations throughout Australasia. Rather, the psychological services provided to child welfare clients are largely based on the governing philosophy of individual agencies. A corresponding lack of research, however, means that such a model, particularly one that addresses the unique needs of child welfare clients in New Zealand and Australia, is not actually in existence.

Furthermore, the data obtained in this study points to a disproportionate increase in the number of child welfare clients to psychological services in both New Zealand and New South Wales. The resulting situation unfortunately sees many vulnerable children and young people, especially those with mild to moderate behavioural and/or emotional difficulties, move through the child welfare system with such difficulties unaddressed.

While this study did not obtain comprehensive data regarding the provision of psychological services to child welfare clients in all jurisdictions throughout Australasia, it did elude a reasonably thorough description of such services in New Zealand and the Australian state of New South Wales. A comparison of the nature and scope of psychological service provision to child welfare clients within these two jurisdictions revealed several critical distinctions in the way such services are delivered. Importantly, these distinctions highlighted the apparent lack of recognition for the unique mental health needs of child welfare clients among professionals working alongside such vulnerable children and young people in New Zealand.

The findings presented in this study represent a fundamental first step in the process of mapping psychological services for child welfare clients in Australasia; however, much is still to be discovered with regard to such an investigation. Given the small scale of this study, it is essential that additional research be conducted in order to fully understand the nature and scope of psychological service provision to child welfare clients in Australasia. In this way, psychologists and other professionals working alongside this vulnerable population can begin to map and consequently identify gaps in the provision of such services to child welfare clients. Future research of this nature would benefit from being conducted on a large scale, in

order to increase the likelihood of obtaining comprehensive information from all jurisdictions throughout New Zealand and Australia.

## **Conclusions**

With good agreement among respondents in this study, the data obtained during the course of this project likely provides an accurate picture of the provision of psychological services to child welfare clients in New Zealand and New South Wales. The findings of this study have highlighted two key phenomena with respect to such services. The first pertains to the utilisation of a ‘best practice’ model among government child welfare and health departments and non-government organisations, of which there appears to be none. The second highlights the disparity between recent trends in the number of children and young people in contact with government child welfare departments and the development of in-house psychological services for such individuals in New Zealand and New South Wales.

In comparing the provision of psychological services to child welfare clients in New Zealand and New South Wales it is apparent that both differences and similarities exist in the delivery of such services between the two. The significant differences that can be identified include the number of psychologists employed by each government child welfare department, the number of non-government organisations servicing the psychological needs of child welfare clients, and the perceived need for and importance of evaluations of child protection services, including psychological services, commissioned by each government. Among the similarities between New Zealand and New South Wales are the practice of receiving referrals from social workers to psychological services within government child welfare departments, and likewise for non-government organisations, the practice of

receiving referrals from the government child welfare department and other non-government organisations, the partnership between government child welfare and health departments in both jurisdictions, and the nature of the professional responsibilities of psychologists in New Zealand and New South Wales.

There are also a number of lessons that each country can learn from the other with regard to the provision of psychological services to child welfare clients. The majority of these are taken from the delivery of such services in New South Wales where a greater recognition of the unique needs of child welfare clients appears to exist among professionals and politicians alike. In drawing on the strengths of psychological service provision in New South Wales, several key elements can be applied to the delivery of such services in New Zealand, including the employment of additional psychologists within the national child welfare department, the development of psychological services within non-government organisations and the importance of regular reviews in order to develop these services further. The establishment of multi-agency psychological services, similar to the unit located in central Auckland which comprise of professionals from the national child welfare department, local District Health Board and New Zealand Police, in New South Wales will likely serve to enhance the delivery of such services to child welfare clients throughout the state.

Neither jurisdiction is without flaws; however, both have valuable contributions to make to the development of psychological service provision to child welfare clients in New Zealand and New South Wales. With a growing awareness of the unique mental health needs of this vulnerable population in both countries, fuelled by psychologists who include in their professional responsibilities advocacy on behalf of such clients, coupled with the trend towards an increasing number of



notifications of child maltreatment to the government child welfare departments in each jurisdiction, the coming years will likely represent an important period in the development of psychological services for child welfare clients across Australasia.

These findings have important implications for psychologists and policy-makers alike, who are charged with the wellbeing of child welfare clients as they attempt to deliver effective psychological services to this vulnerable population. Firstly, there is an obvious need for additional research aimed at developing a model of best practice for the provision of such services to child welfare clients. In this way, such professionals can effectively enhance the delivery of these psychological services by employing an empirically-based model of best practice.

Secondly, the disparity that exists between the number of children and young people brought to the attention of government child welfare departments in New Zealand and New South Wales and the development of in-house psychological services provided by these departments highlights the need for such an issue to be addressed. In order for the child welfare departments in these jurisdictions to meet the demand of the mental health needs of their clients, the scope of in-house psychological services provided by such departments will need to expand considerably.

Finally, the acknowledgement of the unique needs of child welfare clients will benefit from developing among government child welfare departments and non-government organisations alike, especially in New Zealand. This growth will likely be facilitated through the completion of a national review of psychological services due to recommence later this year, coupled with an increase in advocacy by psychologists on the ground level for the mental health needs of child welfare clients.

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